
Maaori Health Plan 2016/17



COUNTIES
MANUKAU
HEALTH





Kind

Manaakitanga

Excellent

Rangatiratanga

Valuing everyone

Whakawhanaungatanga

Together

Kotahitanga

He Pou Koorero

Ko te tumanako a tenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana- taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

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Foreword

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us, and one that we share with our strategic Maaori partner Mana Whenua i Tamaki Makaurau. Our commitment to achieve Maaori health equity is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

Achieving health equity for Maaori will require us to be deliberate in our choices and priorities. It will require shifting or prioritising resources to areas that will achieve health equity for Maaori by accelerating health gains. We will focus our collective actions across the health sector, keeping the advancement of Maaori health at the forefront of planning, funding and service delivery. We must also be transformational in the way we improve performance, and drive innovation and service improvements - if we are not, we will only serve to privilege the status quo.

In 2016/17 we will continue to focus on improving cervical screening rates for wahine Maaori, strengthening and building on the achievements to date. We are committed to increasing breastfeeding rates and will work closely with Lead Maternity Carers, Well Child Tamariki Ora and other maternity and child health providers to encourage and support mothers to breastfeed.

We will continue to reduce Sudden Unexpected Death in Infancy rates in Maaori infants, and maintain the momentum in reducing rheumatic fever rates and increasing immunisation rates for our tamariki Maaori.

To increase Maaori health workforce participation rates and accelerate Maaori workforce development, we will focus on increasing workforce (graduate) supply, implementing effective recruitment and talent sourcing approaches, and attention to job creation and innovative models of employment.

Other indicators of particular importance to our community that are included in this plan are rangatahi mental health, cardiovascular disease and diabetes management and childhood obesity.

This plan has been developed in partnership with Mana Whenua i Tamaki Makaurau and the Counties Manukau Primary Health Organisations (PHOs). This is a reflection of our joint commitment to accelerate Maaori health gain and achieve health equity for Maaori living in our district.

We express our thanks to our partners for their contribution and commitment to the actions in this Plan, and look forward to working together in this coming year.



Dr Lee Mathias
Chair



Geraint A Martin
Chief Executive

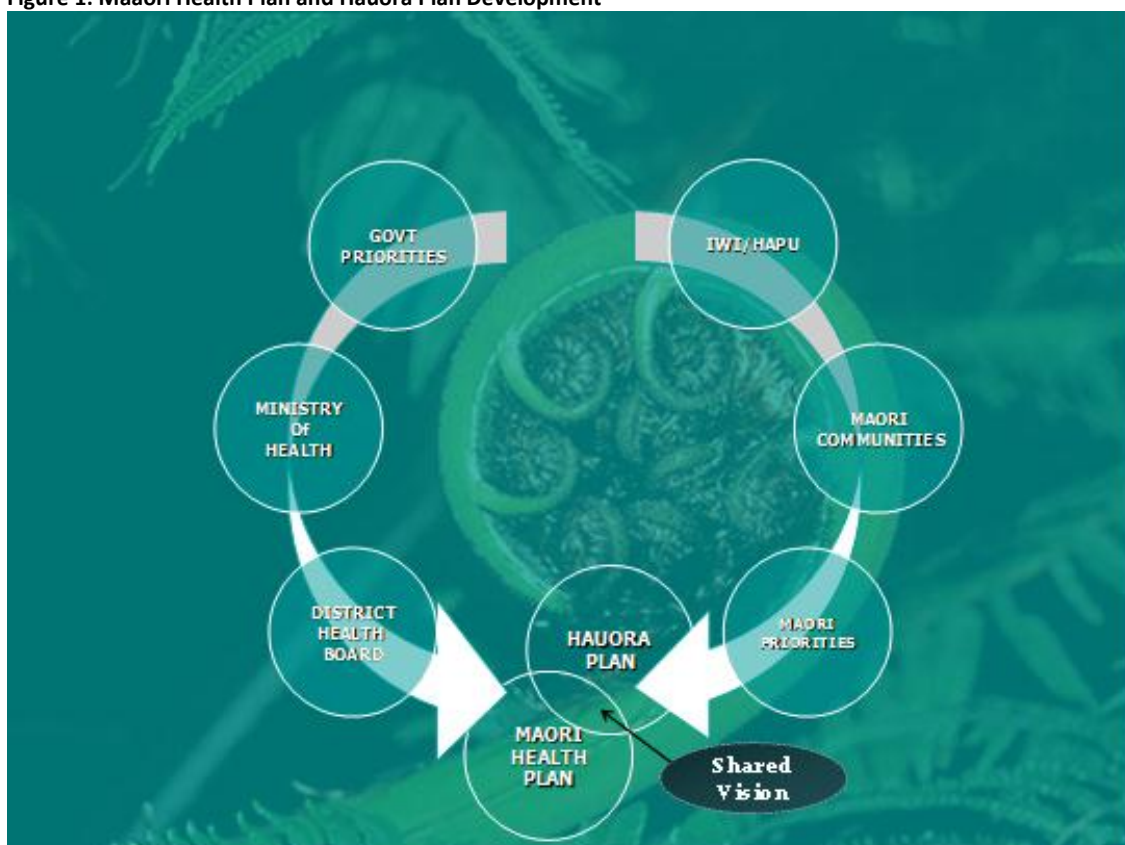
1.0 Introduction

Counties Manukau Health (CM Health) is committed to accelerating Maaori health gain and achieving Maaori health equity. We aim to see Maaori living longer, healthier lives with whaanau and in their communities.

The opportunity and challenge of achieving Maaori health equity is one we share with our treaty partner, Mana Whenua i Tamaki Makaurau and the Counties Manukau PHOs. Our relationship with Mana Whenua i Tamaki Makaurau is an important partnership for CM Health and is integral to moving forward in-step with the local hapu, iwi and Maaori communities.

This plan supports the relationship interests of both CM Health and Mana Whenua i Tamaki Makaurau which are focussed on addressing health inequalities and accelerating the health interests of Maaori in this district. To reflect our relationship with Mana Whenua i Tamaki Makaurau we have integrated their Hauora Plan (Appendix 1) into this Plan.

Figure 1: Maaori Health Plan and Hauora Plan Development



The 2016/17 Maaori Health Plan was developed using a collaborative planning approach and provides a comprehensive collection of evidenced based activities with performance indicators designed to accelerate Maaori health. As part of our commitment to apply health equity to lens to all our planning, we prioritised our planning activities to focus on the Maaori Health Plan first. This then informed development of the Annual Plan.

As part of strengthening and accelerating the implementation of the Te Ara Whakawaiora model in CM Health, additional enablers and support will be established and made available to Te Ara Whakawaiora indicator champions in 2016/17. This includes support to:

- Collate and analyse relevant data
- Identify best practice, excellence and innovation
- Apply continuous quality improvement; and
- Establish indicator steering groups

Implementing this plan and accelerating Maaori health gain will require a collaborative effort and robust leadership across the health system and strong commitment to shared accountability.

2.0 CM Health Strategic Goal and Values

Achieving “Healthy Futures for Maaori” (Paeora) is a priority for CM Health and aligns with our Healthy Together strategic goal. This means:

- Seeing Maaori living longer, healthier lives with whaanau and in their own communities
- Working together to achieve health equity for Maaori communities experiencing health disparities

To achieve this, our transformational challenge is:

“To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality”

We intend to progress and measure our progress over the next 5 years by:

- Advocating for healthier environments and settings that make healthy choices easier
- Better supporting people and families to live well with a diagnosed, long term condition through ways of working that honour Maaori wellbeing
- Targeting service delivery to people at risk. Ensuring Maaori get access to services earlier than they otherwise would, in planned, proactive models of integrated care
- Providing healthcare closer to home. By orientating our service delivery to Localities, services are better connected with Maaori and whaanau and with other health, social and community service providers supporting their wellbeing.

There is a Maaori whakatauki (proverb) that embodies this challenge - “Ko tou rourou, ko toku rourou ka ora ai te iwi.”

If we ask ourselves – how can we achieve health equity and how can we value everyone - we can all contribute to this goal. And there, in our quest for health equity, we can continue to narrow the health gaps.

Our values reinforce our commitment to excellent, collaborative, compassionate and safe healthcare that we aspire to live and breathe every day.



- **Manaakitanga** (Kind)
Care for other people’s wellbeing
- **Rangatiratanga** (Excellent)
Safe, professional, always improving
- **Whakawhanaungatanga** (Valuing Everyone)
Make everyone feel welcome and valued
- **Kotahitanga** (Together)
Include everyone as part of the team

3.0 Working with Mana Whenua

3.1 Mana Whenua i Tamaki Makaurau Board to Board Relationship

The oversight for monitoring progress against the Maaori Health Plan and the Hauora Plan will comprise of:

- Reports against progress to the Counties Manukau District Health Board and Mana Whenua i Tamaki Makaurau Boards; and
- Twice yearly meeting of both Boards to assess progress to date

The framework for governance monitoring is shaped by the four principles set out in the Hauora Plan (Appendix 1). Management of both organisations are responsible for implementing an annual work plan that sets out the activities under these objectives (refer Table 1 below).

Table 1: Hauora Plan Principles and Objectives 2016/17

Hauora Plan Principles	Objectives
Treaty Principle	Strengthen relationships at all levels to provide for shared decision making and partnering
	Establish relationships with Crown agencies and Maaori communities that impact on the social determinants of health
Matauranga Maaori	Review and monitor the training of tikanga best practice as it is applied across all departments of CM Health
	Develop and implement a tikanga framework that is made available to all health services in the region
Service Planning	Establish a collective Maaori knowledge base to support Maaori health and hauora planning
	Regularly consult with Maaori networks to encourage information sharing to improve services planning and identify barriers to Maaori participation
	Develop mechanisms to support Maaori service users to independently: <ul style="list-style-type: none">▪ Identify their wellbeing aspirations and outcomes and to evaluate whether or not services are responding to them
Whaanau based quality	Ensure a conducive health environment exists that encourages whaanau to independently identify hauora and health outcomes
	Implement the whaanau outcome measure for Maaori to evaluate service responsiveness

3.2 Maaori Health Advisory Committee

The Maaori Health Advisory Committee (MHAC) is a Committee of the Counties Manukau District Health Board. In 2016/17 MHAC will continue to provide advice, strategic direction and make robust recommendations to the Counties Manukau District Health Board aimed at the acceleration of Maaori health gains and addressing Maaori health inequities.

MHAC membership comprises Counties Manukau District Health Board members, Mana Whenua and Maaori health expertise from the wider community. This committee is not a substitute of the peer Board to Board relationship with Mana Whenua.

The MHAC will meet four times a year and intends to develop a forum to facilitate community based wananga or learning environments to engage Maaori communities on issues of priority to Maaori health improvement.

4.0 Demographic & Health Profile of Counties Manukau Maaori

4.1 Population Size, Age Distribution, and Growth

The estimated resident Maaori population in Counties Manukau in 2016/17 is 86,010, making up 16 percent of the total population and 12 percent of the New Zealand Maaori population.

In the 2013 Census, 83 percent of Maaori living in Counties Manukau identified with one or more iwi. The most common iwi affiliations were with Te Tai Tokerau or Tamaki Makaurau iwi (51 percent) and Waikato/Tainui iwi (26 percent).

Mana Whenua from the Counties Manukau district comprise eight hapu – Te Aakitai, Ngati Te Ata, Ngati Paoa, Ngai Tai, Te Kawerau A Maki, Ngati Taahinga, Ngati Amaru and Ngati Tipa.

Similar to the national Maaori population, Maaori in Counties Manukau are relatively young compared to the non-Maaori/non-Pacific population. Population estimates for 2016/17 suggest that 34 percent of the Maaori population in Counties Manukau are aged under 15 years, compared to 18 percent of the non-Maaori/non-Pacific population.

By 2036/37, the Maaori population in Counties Manukau is predicted to increase by 43 percent to reach just under 125,000. The non-Maaori population is predicted to increase by 25 percent, with Pacific and Asian populations predicted to increase by 39 percent and 49 percent respectively.

While population growth in the younger age groups is expected, growth in the number of people aged 65 years and older is also important. The proportion of the Maaori population aged over 65 years is projected to increase from 4,310 (5 percent) in 2016/17 to 11,720 (10 percent) by 2036/37. This is a projected increase of 172 percent for the Maaori population aged 65 years and over.

4.2 Social Determinants of Health

At the time of the 2013 Census, 58 percent of the Counties Manukau Maaori population lived in areas classified as being the most socio-economically deprived (NZ Dep 9 and 10) in New Zealand, compared to 17 percent for European/Other and 76 percent for Pacific people living in Counties Manukau.

In 2013, 78 percent of Maaori adults (aged 15 years and over) in Counties Manukau did not own their own home. That figure was 58 percent for the total Counties Manukau population and 41 percent for Paakehaa adults.

In 2013, 38 percent of Maaori tamariki aged 0-14 years were living in crowded households. That figure was 30 percent for the total Counties Manukau population aged 0-14 years and 6 percent for Paakehaa children.

In the 2013 Census, 27 percent of Maaori adults (aged 15 years and over so this included some rangatahi still at school) in Counties Manukau had achieved a post school qualification. The comparative figure for Paakehaa adults was 43 percent.

4.3 Whaanau Wellbeing

Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013) showed that 76 percent of Maaori surveyed in Counties Manukau reported that their whaanau were doing well or extremely well. A high level of connectedness with whaanau was reported and 83 percent of those surveyed said it was easy or very easy to get support from their whaanau.

When asked about the importance of being engaged in Maaori culture, 71 percent of Counties Manukau respondents said it was very, quite, or somewhat important. Fifty-eight percent reported discussing or exploring their whakapapa or family history, 60 percent reported being involved in cultural practices such as singing a Maaori song, haka performance, giving mihi, taking part in Maaori performing arts and crafts, and 79 percent reported watching a Maaori television programme in the last 12 months.

When asked about Te Reo Maaori, 35 percent of those surveyed were able to understand Te Reo Maaori very well, well, or fairly well; 25 percent were able to speak Te Reo Maaori very well, well, or fairly well; and 19 percent used Te Reo Maaori regularly in their home. Two-thirds of Maaori surveyed reported wairua (spirituality) being very, quite or somewhat important to their well-being.

4.4 Life Expectancy

Overall life expectancy (2012-2014 average) at birth for Maaori living in Counties Manukau is 74.5 years. However, while Maaori life expectancy has been improving at a similar absolute rate compared with the non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific is nine years.

4.5 Disability

Based on the national 2013 Disability Survey¹, it is estimated there are approximately 20,000 Maaori people with disability living in Counties Manukau, 25 percent of the total Maaori population of Counties Manukau, and 18 percent of all people in Counties Manukau living with disability.

The most frequent type of impairment for Maaori adults is physical impairment, followed by sensory impairment, 'other' impairments including impaired speaking, learning and remembering, psychiatric/psychological impairment, and intellectual impairment.

For Maaori children, the most frequent type of impairment is 'other' impairments (including impaired speaking, learning and development delay), followed by psychiatric/psychological, sensory, intellectual, and physical impairments.

The most frequent cause of impairment for Maaori adults is disease or illness. Injury is also a frequent cause in Maaori adults aged less than 65 years.

For Maaori children, the most frequent causes are conditions that existed at birth, disease or illness, and conditions that are categorised in the Survey as 'other causes' (including conditions on the autism spectrum, attention deficit hyperactivity disorder, developmental delay, dyslexia and dyspraxia).

4.6 Avoidable Mortality

Leading causes of avoidable mortality² for Maaori in Counties Manukau are ischaemic heart disease, lung cancer, diabetes, suicide and self-inflicted injuries, cerebrovascular diseases, and breast cancer (females). The top five causes by gender are listed below.

Table 2: Leading causes of Avoidable Mortality for the Counties Manukau population aged 0-74 years, 2010-2013

Ethnic group	Males	Females	Total
Maaori population	Ischaemic heart disease	Ischaemic heart disease	Ischaemic heart disease
	Lung cancer	Lung cancer	Lung cancer
	Diabetes	Breast cancer	Diabetes
	Suicide & self-inflicted injuries	Diabetes	Suicide & self-inflicted injuries
	Liver cancer	Cerebrovascular disease	Cerebrovascular disease and Breast cancer
Non-Maaori/Non-Pacific population	Ischaemic heart disease	Breast cancer	Ischaemic heart disease
	Lung cancer	Lung cancer	Lung cancer
	Cerebrovascular disease	Ischaemic heart disease	Cerebrovascular disease
	Colorectal cancer	Cerebrovascular disease	Colorectal cancer
	Suicide & self-inflicted injuries	Colorectal cancer	Suicide & self-inflicted injuries

Reducing smoking prevalence and obesity, and improving cardiovascular risk management, nutrition and physical activity would contribute significantly to reducing the leading causes of mortality. Encouragingly, the Counties Manukau Maaori population smoking prevalence fell from 47 percent at the 2006 Census to 36 percent in the 2013 Census. However, smoking prevalence among Maaori is more than double that of the overall Counties Manukau population, and smoking prevalence among Maaori women aged 20 to 50 years is more than 40 percent.

¹ Disability is defined in the 2013 Disability Survey as 'an impairment that has a long-term, limiting effect on a person's ability to carry out day-to-day activities'

² Avoidable mortality includes deaths occurring among people less than 75 years of age that could potentially have been avoided through population-based interventions or through preventive and curative interventions at an individual level. Leading causes are determined by absolute numbers, rather than rates, to reflect the burden of disease for our community and health system.

4.7 Avoidable Hospitalisations

Avoidable hospitalisation³ rates for Maaori living in Counties Manukau are significantly higher than the non-Maaori/non-Pacific rates. The leading five causes⁴ of avoidable hospitalisation for the Counties Manukau Maaori population aged less than 75 years are cellulitis, angina and chest pain, respiratory infections, asthma, and gastroenteritis (Table 3).

Table 3: Leading causes of Avoidable Hospitalisations for the Counties Manukau population, 2013- 2015

Ethnic group	0-14 years	15-44 years	45-64 years	65+ years
Maaori population	Respiratory infections	Cellulitis	Angina & chest pain	COPD
	Dental conditions	Angina & chest pain	COPD ⁵	Respiratory infections
	ENT infections	Kidney/urinary infection	Cellulitis	Congestive heart failure
	Asthma	Asthma	Diabetes	Angina & chest pain
	Cellulitis	Sexually transmitted diseases	Respiratory infections	Diabetes
Non-Maaori/Non-Pacific population	Gastroenteritis	Angina & chest pain	Angina & chest pain	Angina & chest pain
	ENT infections	Cellulitis	Cellulitis	Skin cancers
	Dental conditions	Gastroenteritis	Myocardial infarction	Respiratory infections
	Respiratory infections	Sexually transmitted diseases	Gastroenteritis	COPD
	Epilepsy	Kidney/urinary infection	Respiratory infections	Congestive heart failure

4.8 Primary Health Organisation Enrolment

In estimating the percentage of Maaori enrolled in a Primary Health Organisation (PHO), it is important to be aware of the differences between ethnicity as recorded in the PHO enrolment register, ethnicity as recorded against the NHI, and ethnicity of the estimated resident population projections based on the 2013 Census. Comparisons suggest that ethnicity data derived from both PHO and the National Health Index (NHI) datasets underestimate Maaori and Asian populations while over estimating Pacific and European/Others. It seems likely that some people identified as Pacific or European/Other in the PHO register would be identified and prioritised as Maaori or Asian in Census-based population projections.

It is also important to be aware that there are different 'views' of the enrolled population. Presented below is the enrolment data for Maaori who are resident in the Counties Manukau area and who are enrolled with any PHO (some practices and PHOs are outside the Counties Manukau area). Another 'view' is that of Maaori who are enrolled with practices within the Counties Manukau area and who may live inside or outside the Counties Manukau area boundary. Based on PHO enrolment data for October - December 2015, 78,249 Maaori living in Counties Manukau are enrolled in a PHO, 94 percent of the estimated resident Maaori population for 2015⁶. Just under half the Counties Manukau Maaori population is enrolled in practices that are part of the Procure PHO. Twenty-three percent of Maaori are enrolled with Total Healthcare practices, 16 percent with Alliance Health+, eight percent with National Hauora Coalition, and four percent with East Health.

Table 4: PHO enrolment for Maaori resident in Counties Manukau⁷

PHO	Number of Maaori enrolled	Percentage of total Maaori enrolled
Procure	37,903	48%
Total Healthcare	17,664	23%
National Hauora Coalition	6,417	8%
Alliance Health+	12,293	16%
East Health	3,241	4%
Other PHOs	731	1%

³ Avoidable hospitalisations includes hospitalisations of people aged under 75 years of age that could potentially have been avoided through population based measures or through prevention, early detection and treatment of conditions.

⁴ Leading causes are determined by absolute numbers, rather than rates, to reflect the burden of disease for our community and health system.

⁵ Chronic Obstructive Pulmonary Disease (COPD) characterized by chronic lung airflow obstruction that interferes with normal breathing.

⁶ Denominator used for this calculation is the estimated resident population for 2015 (n=83,160), based on the 2013 Census (Stats NZ 2015 update of Population Projections).

⁷ Data for the period October - December 2015, sourced from PHO Register.

5.0 National Indicators

5.1.1 Data Quality

Improve the accuracy of ethnicity reporting in PHO registers

Accurate ethnicity data is a “necessary and critical step” in tackling health inequalities. Issues with misclassification of ethnicity data arise in all health data sources, including in primary care, resulting in an undercount of Maaori, Pacific and Asian ethnicities. Self-reported ethnicity data is important, not only for the accurate monitoring and reporting of programme performances, but also for appropriate targeting of individual patients and resources for certain programmes.⁸ Accurate ethnicity data is important for informing the public and the health sector, identifying health need, service planning and funding, and monitoring activities. However there is currently inconsistency in the quality of health sector ethnicity data collection.

CM Health achieved implementation of the three stages of the Ethnicity Data Audit Tool (EDAT) in 95% of its general practices during the 2015/16 year. PHOs were strongly engaged in the implementation process and are supportive of a continued focus on improving the quality of ethnicity data in general practice settings. During the 2016/17 year, CM Health will work with the PHOs and general practices in the district to carry out further analysis of the EDAT Stage 3 results and to develop and implement sustainable systems and processes for collection, recording and reporting of accurate and high quality ethnicity data in line with the Ethnicity Data Protocols for the Health and Disability Sector. All activity will be aligned with roll out of the National Enrolment Service (NES) guidelines and Business Rules.

Percentage of general practices in two CM Health PHOs who have completed the three stages of EDAT

2015/16 Baseline Q3	2016/17 Target
99%	100%

Who will we work with?

- CM Health PHOs
- Ministry of Health
- Monitoring Processes**
- Quarterly reporting to the Maaori Health Advisory Committee, ELT & ALT
- Regular reporting on progress to PHOs

Actions

- Q1-Q2: Complete analysis of ethnicity data for 9,000 patients collected in Stage 3 of the EDAT implementation. Identify ethnicity misclassification issues and work with each PHO to develop a quality improvement plan to address the issues
- Q1: Complete analysis of the enrolment forms used by general practices in each of the CM Health PHOs to ensure they align with the Ethnicity Data Protocols and the NES Business Rules
- Q1: CM Health will work with PHOs to produce a small ethnicity data quality guide for PHOs. This will include learning and practical tips garnered from the 2015/16 EDAT implementation
- Q2-Q4: PHOs to ensure that 100% of CM Health practices are using enrolment forms that are aligned with the Ethnicity Data Collection Protocols
- Q2-Q4: PHOs to set up systems for all new practice staff (and new practices coming into their PHO) to be provided with training on the Ethnicity Data Protocols, the importance / relevance of ethnicity data, accuracy in recording ethnicity and tips on how to ask patients about their ethnicity. PHOs will provide this training for new practices and practice staff from Q2-Q4 during the 2016/17 year
- Q2-Q4: PHOs to conduct an annual query on each of their practices' PMS to find the number of 54 and 61 'Other' codes (often used when the patient's ethnicity is unknown). PHOs will work with each practice to follow up with patients to ask about and update their records with accurate ethnicity details

Measures

- Each PHO has an ethnicity data quality improvement plan completed by Q2
- Analysis of PHO enrolment forms in CM Health PHOs and practices is completed by Q1
- An ethnicity data quality guide for CM Health PHOs is completed by Q1
- 100% of CM Health general practices are using enrolment forms that are aligned with the Ethnicity Data Collection Protocols by Q4
- All CM Health PHOs have systems in place to provide training to new practices / new practice staff on the Ethnicity Data Protocols, the importance of ethnicity data, accuracy in recording ethnicity and tips on how to ask patients about their ethnicity by Q4
- Training on Ethnicity Data Protocols is provided by PHO for new practices and practice staff from Q2-Q4 during the 2016-17 year
- PHOs carry out an annual query on each of their practices' PMS to find the number of 54 and 61 'Other' codes. PHOs will work with each practice to follow up with patients to ask about and update their records with accurate ethnicity details by the end of Q4

⁸ Ministry of Health. (2013). Primary Care Ethnicity Data Audit Toolkit: A toolkit for assessing ethnicity data. Wellington: Ministry of Health found at <http://www.health.govt.nz>.

5.1.2 Access to Care - PHO Enrolment

<p>Increase Maaori engagement in primary care and improve PHO enrolment rates</p> <p>Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment will improve access to primary care services that enable early intervention and reduce health disparities between Maaori and non-Maaori.</p> <p>Increasing Maaori newborn enrolment in primary health care organisations (PHOs) is important so they can access health services, and health and social interventions to give them the best start in life.⁹</p>	Percentage of Maaori enrolled in PHOs		2015/16 Baseline Q3	2016/17 Target
			95%	100%
	<p>Who will we work with?</p> <ul style="list-style-type: none"> CM Health PHOs <p>Monitoring Processes</p> <ul style="list-style-type: none"> Maaori enrolment rates via Trendly Quarterly reporting to the Maaori Health Advisory Committee and to PHOs 			
<p>Actions</p> <p>Improve Maaori enrolment in PHOs</p> <ul style="list-style-type: none"> Q1: PHOs to ensure all practices are aware of Maaori enrolment target Q1–Q4: DHB and PHOs review, compare and monitor Maaori enrolment data on a quarterly basis Q3–4: Work with PHOs to develop key messages and promotional material targeted at improving Maaori enrolment in a PHO. Support PHOs to deliver the awareness messages and promotional activities Q1–4: Work with Maaori community health services providers to raise awareness of the importance and benefits of enrolment with a PHO Q1–4: Work with PHOs to review each PHO's newborn enrolments plan, activities and performance on a quarterly basis Q1–4: Support PHOs to identify and address issues where performance is not improving sufficiently to meet the target of 98% of newborns enrolled by 3 months 	Measures			
	<ul style="list-style-type: none"> Discussions held with all CM Health PHOs on Maaori enrolment rates by Q1 All CM Health PHOs have demonstrated that they have communicated with their practices on the importance of Maaori enrolment and the Maaori PHO enrolment target by Q2 Maaori community providers are have delivered key messages that focus on improving Maaori enrolment in PHOs by Q4 PHO newborn enrolment plans and performance reviewed on a quarterly basis Quality improvement initiatives developed and implemented on a quarterly basis where relevant. This will be reviewed on a quarterly basis 			

5.1.3 Access to Care – Avoidable Hospitalisations

<p>Reduce avoidable hospitalisations in Maaori</p> <p>Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting.</p> <p>Age has a significant impact on admissions for some conditions, especially for newborns and children. For children (29 days – 14 years) dental, otitis media/upper respiratory tract infections, asthma, gastroenteritis, pneumonia and cellulitis/skin infections are the major causes of ASH admissions. Angina, congestive heart failure, pneumonia and gastroenteritis admissions increase significantly as people age. Maaori and Pacific peoples had significantly higher admissions for asthma, congestive heart failure, epilepsy, pneumonia and cellulitis/skin infections.¹⁰ Maaori rates of dental caries are higher than for non-Maaori ethnic groups, and excess sugar intake is the principal cause of dental caries. Hand washing and food safety are key components of preventing gastroenteritis, the disease responsible for the greatest burden of ASH in the district for children aged 0 to 4 years.</p> <p>By reducing risk factors and taking appropriate early intervention, many conditions can be prevented or managed without the need for hospital level</p>	Ambulatory Sensitive Hospitalisation rates¹¹		2015/16 Baseline Q3	2016/17 Target
	Maaori	Age 0-4	6,811 per 100,000	5,650 per 100,000
		Age 45-64	8,457 per 100,000	6,029 per 100,000
	Total	Age 0-4	7,348 per 100,000	N/A
		Age 45-64	4,547 per 100,000	N/A

⁹ Ministry of Health. (2014). Well Child Tamariki Ora Programme Delivery for 2013. Wellington: Ministry of Health.

¹⁰ Health Quality and Safety Commission. (2015). The Atlas of Healthcare Variation. Wellington: Health Quality and Safety Commission
<http://www.hqsc.govt.nz/our-programmes>.

¹¹ Note that 45 to 64 year old rates are age standardised, whereas 0 to 4 year old rates are not.

<p>care. Keeping people well and out of hospital is a key priority; not only is it better for our population, but it frees up hospital resources for people who need more complex and urgent care.</p> <p>Since rates of ASH for Maaori preschool children in CM Health are within 5% of national 'total' rates, a local equity target of a 50% decline, toward the rate for 'Other' ethnic groups (4,489/100,000/year) is proposed. Rates of ASH for Maaori adults in CM Health (45 to 64 years) are well above national rates, so a 50% decline toward the national total rate (3,600/100,000/year) is proposed.</p>				
Actions	Measures			
<p>Targeted actions to reduce ASH rates for Maaori 0-4 years</p> <ul style="list-style-type: none"> Q1-Q4: Increase newborn enrolment rates with PHOs, general practice and Well Child Tamariki Ora – refer section 5.1.2 Q1-Q4: Increase the percentage of Maaori infants breastfed – refer section 5.1.4 Q1-Q4: Increase immunisation rates and timeliness of immunisation for Maaori tamariki – refer section 5.1.8 Q1-Q4: Improve enrolment with and access to oral health services for Maaori tamariki – refer section 5.1.10 Q1-Q4: Provide admission data to practices which identify tamariki under 5 years who are eligible for funded flu immunisation and support practices to recall and immunise eligible tamariki Design and implement a 'water and milk' only policy, eliminating sugary drinks, for high deprivation preschools and primary schools in the Counties Manukau district <ul style="list-style-type: none"> Q1: Water and milk only policy developed At least 5 preschools and 3 primary schools engaged by Q4 Q1-Q4: Design and implement a hand washing and food safety training component ('clean, cook, cover, chill') to established WCTO providers Q1: Deliver training to WCTO providers on early identification and treatment of skin infections and key messages for families for preventing skin infections ('clean, cut, cover') Q1-Q4: Promote the regional clinical pathways and skin resources for skin infections to WCTO providers by Q1 and primary care in Q2-Q4 Q4: Establish a clinical nurse specialist service to provide clinical advice to WCTO providers around the management of skin conditions Q1-Q4: Identify Maaori tamariki with asthma and ensure 100% of families have access to self-management support and action plans Q1-Q2: Scope up including long-term asthma management into the Mana Kidz Programme. Note: dependent on securing ongoing programme funding) <p>Targeted actions to reduce ASH rates for Maaori 45-64 years</p> <ul style="list-style-type: none"> Q4: A minimum of 2 nurse-led clinics for skin conditions are established across CM Health by Q4 to: <ul style="list-style-type: none"> Develop Clinical Nurse Specialist support for primary care nurses in general practice clinics using new role if approved Identify those Maaori patients that have complex and frequent use of hospital services related to skin conditions Work with general practices with Maaori patients with complex skin conditions ensuring use of enablers such as At Risk, care coordination, e-shared care and connection with specialist teams are working Use clinical pathways to ensure consistency of care messages and approaches 	<ul style="list-style-type: none"> Refer to section 5.1.2 Refer to section 5.1.4 Refer to section 5.1.8 Refer to section 5.1.10 100% of eligible tamariki identified and families contacted Policy developed by Q1 At least 5 preschools and 3 primary schools engaged in discussion of policy by Q4 Hand washing and food safety components developed by Q1 Food safety and skin infection training provided to the 4 CMDHB WCTO providers by Q4 Clinical pathways and resources promoted, and training provided to the 4 WCTO providers and 100% of primary care by Q4 Clinical nurse specialist service established by Q4 100% of families have access to self-management support and action plans 2 Nurse led-primary care clinics established by Q4 Refer section 5.1.7 and section 2.2.5 of the CM Health Annual Plan 			

Reduce smoking prevalence and smoking related-harm amongst Maaori

- Q1-Q4: Reduce smoking prevalence and smoking related-harm amongst Maaori – refer section 5.1.7 of this document and section 2.2.5 of the CM Health Annual Plan

Diabetes Management

- Q1-Q4: Improve diabetes management - refer section 6.1.4
- Q1-Q4: Improve the percentage of patients with diabetes tested for microalbuminuria and on ACE or ARB
- Q1-Q4: Reduction in the proportion of patients with an HbA1c above 64, 80 and 100 mmol/ml

Cardiovascular Disease (CVD) Risk Assessment & Management

- Q1-Q4: Early identification, support and management of CVD amongst Maaori – refer section 6.1.3
- Q1-Q2: Report the dispensing rates for Maaori and non-Maaori patients
- Q3: Develop a supportive care model in partnership with clinical nurse specialists, community nursing and primary care
- Q 3-Q4: Reduce the gap in dispensing rates between Maaori and non Maaori
- Q1-Q4: Identify Maaori patients at risk and ensure they are accessing appropriate care such as the ARI programme
- Q1-Q4: Encourage utilisation of care pathways to ensure appropriate treatment and care plan for Maaori patients

Note and linkages: Actions supporting immunisation, breastfeeding, B4 School Checks, cardiovascular disease and smoking cessation make a significant contribution to reducing respiratory illness, Ear, Nose and Throat conditions, diabetes and cardiovascular disease. These are covered in other sections of this Plan.

- Refer to section 6.1.4

- Refer to section 6.1.3

5.1.4 Child Health - Breastfeeding

Increase the percentage of Maaori infants breastfed

Exclusive breastfeeding is recommended by the World Health Organisation for the first six months of an infant's life to support healthy infant growth and development. Breastfeeding has numerous benefits, supporting infant development and immune protection, protecting against Sudden Unexpected Death in Infancy (SUDI), respiratory illness and chronic otitis media, childhood obesity, diabetes and recognition of traditional Maaori nurturing of tamariki and mokopuna.

Research in New Zealand indicates that for Maaori, having a breastfeeding culture in the whaanau, appropriate and accessible professional support and accurate knowledge about breastfeeding are keys to establishing and continuing breastfeeding.¹²

We are committed to increasing breastfeeding rates for Maaori women to equal to or greater than the breastfeeding rates for the total population. Our vision is that women and their whaanau in Counties Manukau will have the information they need to make confident and informed decisions about

breastfeeding, and live and work in an environment that enables and supports their decisions. A consistent standard of breastfeeding knowledge and skills needs to be available for women and their whaanau in the wider community, so that they will be encouraged to initiate and continue breastfeeding, and view it as the best food source for their infants.

Given that breastfeeding rates in Counties Manukau have either remained relatively stable or well below target, a breastfeeding planning workshop was held in December with stakeholders working in maternal and child health in Counties Manukau. The

Percentage of infants exclusive or fully breastfed		2015/16 Baseline Q2	2016/17 Target
Maaori	LMC discharge 4-6 weeks	52%	75%
Total		58%	
Maaori	3 months	37%	60%
Total		46%	
Percentage of infants receiving breast milk		2015/16 Baseline Q2	2016/17 Target
Maaori	6 months	48%	65%
Total		62%	

¹² National BreastFeeding Committee of New Zealand, (2009). National Strategic Plan of Action for Breastfeeding 2008-2012. Wellington: Ministry of Health found at <http://www.moh.govt.nz>.

purpose of the workshop was to identify issues and barriers and to develop practical and achievable actions across the health system and in our communities that will accelerate health gain for Maaori and reduce inequities in rates of breastfeeding.

The recommendations from the workshop have informed the actions below and key stakeholders will come together in Quarter 1 to develop a joint Breastfeeding Action Plan with a focus on Maaori mothers and whaanau. Te Rito Ora, CMDHB's breastfeeding service, will move into phase 2 in 2016/17 expanding to the full Manukau and Otara/Mangere localities and incorporate in the external evaluation findings to improve the services again with a focus on reaching, engaging and effectively supporting Maaori mothers to breastfeed.

Actions

In partnership with Lead Maternity Carer (LMC), Well Child Tamariki Ora (WCTO) providers and other key stakeholders develop a joint Breastfeeding Action Plan to improve breastfeeding rates in Counties Manukau with a focus on Maaori mothers and whaanau

- Q1: Joint workshop to discuss and develop draft plan
- Q2: Finalise plan
- Q3-4: Implement plan

Ensure that Maaori whaanau have access to evidence based breastfeeding education antenatally to inform them about the benefits and management of breastfeeding

- Q1: Workshop to discuss changes needed to align and strengthen breastfeeding services for Maaori in Counties Manukau
- Q1-Q4: B4Baby service provides kaupapa Maaori in-home antenatal breastfeeding education and postnatal support until the baby is six-months old.
- Q1-Q4: Provide targeted antenatal and early parenting education to Maaori and Pacific women and whaanau using revised curriculum with a core focus on actively supporting breastfeeding
- Q1-Q4: Delivery of a series of Whaanau Hapu Waananga (comprehensive childbirth and antenatal education programme) – refer SUDI section

Support mothers to establish breastfeeding

- Q1-Q4: Secondary care facility based Breastfeeding Advocates provide support and information to support mothers to establish breastfeeding
 - Q1: Review and strengthen Breastfeeding Advocate roles to ensure seamless continuity of breastfeeding support from birthing facility into the community
- Q1-Q4: Provide information about and refer mothers and whaanau to primary care and community based breastfeeding support services on discharge
- Q1-Q4: Maintain Baby Friendly Hospital Initiative (BFHI) accreditation

Ensure that Maaori whaanau continue to have access to appropriate breastfeeding support and information in the community and after they are discharged from birthing facility and/or their LMC to maintain breastfeeding to six months

- Q1: Identify and implement (Q2-4) ways to improve referral processes and communication between hospital/birthing facilities and targeted Maaori community breastfeeding support services (Te Rito Ora and B4Baby) to ensure women and whaanau are supported and connected with services as they transition from DHB care back to the community
- Q1-Q4: Provision of Te Rito Ora community based breastfeeding and baby feeding services: drop in breastfeeding clinics, Kaitipua Ora volunteers (mother-to-mother peer supporters), and community and home based lactation consultant service. Maaori are one of the 3 priority populations for this service
 - Q1: Roll out of phase 2 of Te Rito Ora services based on evaluation findings to strengthen the service model including moving to a localities based model
 - Q1-Q4: Ongoing external evaluation of Te Rito services with a focus

Who will we work with?

- Well Child Tamariki Ora Providers: Plunket, Papakura Marae Tamariki Ora, Raukura Hauora o Tainui Mokopuna Ora.
- LMCs
- Primary Care
- Turuki Health Care

Measures

- Increased uptake and engagement in antenatal education
- Increased percentage of infants exclusively breastfed at discharge
- Breastfeeding policy
- Maternity services staff up-to-date with BFHI breastfeeding education requirements
- Referral processes established
- Improved communication between hospital/birthing facilities and community breastfeeding support services
- Breastfeeding action plans developed by end of Q1
- LMC BFCI accredited
- Steering group established
- Indicator Champion appointed
- Maternity and child health provider forum established
- Improved integration between health providers

on acceptability and improved outcomes for Maaori. Evaluation findings will be feedback into the programme to guide improvements

- Q1: Increase LMC, WCTO, primary care and community awareness about services and referral processes
- Q2: Breastfeeding support groups established for Maaori mothers and whaanau
- Primary Birthing Unit Breastfeeding Clinics based at Botany and Pukekohe
- Work collaboratively with WCTO providers to strengthen the support they provide breastfeeding mothers and whaanau
 - Q1: Meet with WCTO providers in Counties Manukau to discuss support requirements and develop WCTO breastfeeding action plan. Plans to be developed by each of the WCTO providers by the end of Q1
 - Q2-4: Support implementation of the action plans
 - Deliver breastfeeding educations sessions – see below
- Q1-Q4: Encourage and support LMCs who are interested to become BFCI accredited through educating about requirements and support with costs
- Q2: Set up of a community based breast pump loan service

Support breastfeeding services that are coordinated and delivered with a community development focus

- Q1: Establish a breastfeeding steering group and identify and appoint a Breastfeeding Champion to drive and coordinate work to improve Maaori breastfeeding rates
- Q1-Q4: Promote collaboration among maternity and child health providers
 - Q1 & Q4: Establish shared forum for sharing information about services, learnings and best practice, planning, and networking
 - Q1: Investigate shared training opportunities
 - Q1-Q4: Clinical champions in the PHOs and 2 LMC liaison midwife roles
 - Q2: Identify a key breastfeeding contact/champion within each organisation

Improve health professionals breastfeeding knowledge to support a consistent standard of breastfeeding knowledge, messages and skills to be available to women and whaanau

- Support LMC to become BFCI accredited – see above.
- Q1-Q4: Deliver breastfeeding education sessions to health professionals and organisations
- Q1: Develop the internal workforce mentorship capacity and capability within selected maternity and child health organisations to train and mentor their workforce in the 3-Step Health Literacy Model (Te Rito Ora Workforce Development and Training initiative)

Link breastfeeding initiatives and activities with childhood obesity activities

- Q1-Q4: Delivery of Te Rito Ora infant and toddler nutrition initiative that focuses on breastfeeding and healthy eating for infants and toddlers:
 - Delivery of healthy eating and cooking workshops
 - Delivery of workforce development initiative that includes increasing confidence of health professionals to have difficult conversations with parents about their child being overweight/obese
- Q1-Q4: Infant and child nutrition expert advisory group to provide oversight over breastfeeding and childhood obesity activities

Monitoring Processes

- Quarterly report to MHAC, ELT & ALT
- External evaluation of Te Rito Ora services

5.1.5 Cancer – Cervical Screening

Improve early detection and early intervention for cervical cancer in Maaori wahine

Cervical cancer is preventable, and the National Screening Unit recommends cervical screening for early identification of cervical cancer and prevention of invasive disease. Maaori have a lower coverage rate for cervical screening compared with non-Maaori. Improving cervical screening coverage rates for Maaori will support a reduction in Maaori cervical cancer mortality.

A framework has been developed to guide health practitioners, health organisations and the health system to achieve equitable health care for Maaori. The framework is endorsed by the National Screening Unit. To improve the number of eligible Maaori women who are screened for both cervical and breast cancer the following principles are required:

- Leadership – by championing the provision of high-quality health care that delivers equitable health outcomes
- Maaori knowledge – developing a knowledge base about ways to effectively deliver and monitor high-quality health care for Maaori
- Commitment – to providing high-quality health care that meets the health care needs and aspirations of Maaori¹³

During the 2015/16 year CM Health and PHOs in the district worked together on key activities to improve cervical screening coverage. This included development of a district-wide cervical screening action plan which was approved by the Alliance Leadership Team.

Each PHO then developed a PHO-specific cervical screening action plan. A High Needs Cervical Screening Coordinator has been working with PHOs and within community settings such as marae, temples and outreach clinics to deliver smear taking services for Priority Group Women. In addition, the DHB and PHOs have taken a leadership role within the sector to improve the quality, accuracy and timeliness of cervical screening coverage data.

Activity during the 2016/17 year will build on the achievements to date with the expectation that this will translate into real improvements in cervical screening coverage, particularly for Maaori women who are overdue for a cervical smear or who have never been screened.

Actions

- Q1: Carry out analysis to better understand the barriers to cervical screening for Maaori women in the CM Health district. Use this information to inform service planning
- Q1: CM Health and the PHOs in the district will work together to update the district-wide and PHO level cervical screening action plans. The plans will focus on improving screening coverage for Maaori and other Priority Group Women, particularly those who are unscreened and under screened
- Q1-4 CM Health PHOs will ensure there is a named coordinator in the PHO and cervical screening champions in practices who are responsible for actions to improve cervical screening coverage
- Q1-4: CM Health will improve access to cervical screening for Maaori women by contracting with PHOs to provide free smears for Priority Group Women
- Q1-4: Each PHO will access the monthly cervical screening data match reports and will use the reports to carry out data matches, to identify women who are overdue for their three yearly cervical smears and to target recall, invite, engagement and smear-taking activity at this group

Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 months

	2015/16 Baseline Q3	2016/17 Target
Maaori	67%	80%
Total	74%	

Who will we work with?

- CM Health PHOs
- Independent Service Providers
- Maaori Health providers
- Maaori service users

Monitoring Processes

- Quarterly reporting to the Maaori Health Advisory Committee and to PHOs
- Reporting against the PHO Cervical Screening Action Plans

Measures

- Analysis on barriers to cervical screening is completed by the end of Q1 and used to inform service planning
- CM Health district-wide and PHO-level cervical screening action plans are completed for the 2016-17 year by the end of Q1
- Cervical Screening Action Plans prioritise actions and outcomes for Maaori and other Priority Group Women
- Each PHO has a dedicated cervical screening coordinator and PHOs work with their general practices to support the establishment of a cervical screening champion role by the end of Q4
- Contracts with each PHO for free smears for Priority Group Women are in place by the end of Q1

¹³ Cram F. (2014). Improving Maaori Access to Cancer Health Care: Literature Review. Auckland <http://www.katoa.net.nz>: Katoa Ltd.

<ul style="list-style-type: none"> Q1-4: CM Health will work with PHOs to provide training for practice staff on how to have the conversations about cervical screening Q1-4: CM Health will work with PHOs, practices and Independent Service Providers (ISP) to implement the cervical screening referral pathway for Priority Group Women Q1-4: CM Health will employ a High Needs Cervical Screening Coordinator to work with general practice teams that have low screening coverage rates for Maaori women and to assist with smear-taking, recall and invite and quality improvement systems Q1-4: The CM Health High Needs Cervical Screening Coordinator will work closely with Maaori health care providers and PHOs to deliver smear-taking clinics in settings that are appropriate and acceptable for Maaori women Q1-4: The CM Health High Needs Cervical Screening Coordinator will work within community settings and with local media to raise cervical screening awareness and to ensure messages are targeted at Maaori women 	<ul style="list-style-type: none"> PHOs are accessing and actively managing monthly cervical screening data match lists on a quarterly basis Number of training sessions provided for CM Health practices on how to have the conversations about cervical screening by Q4 Quarterly description of activity related to the ISP cervical screening referral pathway for Priority Group Women Quarterly description of support provided within practices Three yearly cervical screening coverage rates for Maaori Quarterly description of smear taking activity/clinics provided in community settings Quarterly description of activity to raise cervical screening awareness, particularly amongst Maaori women Reduction in Maaori DNA rate for colposcopy services by 10% by the end of Q3 Patient satisfaction with the colposcopy service is greater than 80% of very good and excellent by the end of Q4
Colposcopy <ul style="list-style-type: none"> Q1-4: Ensure early engagement with Maaori and other vulnerable women who require colposcopy services by using a dedicated Community Health Worker to facilitate access to care Q3-4: Develop and implement colposcopy education sessions with primary care GPs and nurses to raise awareness of the service and with a focus on Maaori and other vulnerable women 	

5.1.6 Cancer – Breast Screening			
<p>Improve early detection and early intervention for breast cancer in Maaori wahine</p> <p>Breast cancer is the second leading cause of cancer mortality for Maaori wahine. The National Screening Unit recommends breast screening to identify breast cancer early, enable earlier treatment, and reduce breast cancer morbidity and mortality. Maaori are one of the priority groups for the national BreastScreen Aotearoa programme. BreastScreen Counties Manukau (BSCM) and CMDHB are committed to increasing breast screen coverage rates among eligible Maaori wahine through BSCM and addressing barriers which impede access and uptake of breast screening.¹⁴</p> <p>BSCM has detailed invitation and recall processes designed to improve appointment processes, patient monitoring and follow – up. These processes include letters, texts, phone calls and home visiting.</p> <p>The service has employed Kaimahi to provide transport, education if required, support and navigation for women as well as promoting the service in the community. Referrals are also made to the ISP for transport as appropriate.</p>	<p>Percentage of eligible women aged 50-69 years who have had a BSA mammogram in the past 24 months</p>	<p>2015/16 Baseline Q3</p>	<p>2016/17 Target</p>
	<p>Maaori</p>	<p>63.5%</p>	<p>70%</p>
	<p>Total</p>	<p>66.4%</p>	
		<p>Who will we work with?</p> <ul style="list-style-type: none">▪ BreastScreen Counties Manukau (BSCM) – the lead provider for the DHB region▪ BSCM will work with primary care practices in the region and the Independent Service Provider▪ NZBCF to support the production of a DVD promoting the programme to Maaori women	
<p>Actions</p> <p>Identification of women who have not been screened or are under screened by:</p> <ul style="list-style-type: none">▪ Data matching with Primary Care practices – data matching allows for identification of women who are not enrolled in the BSA programme and also provides updated contact details for women who are enrolled but may have moved or changed their telephone numbers▪ Data matching with CMDHB Patient management system, provides the same outcomes as primary care data matching but may also identify	<p>Measures</p> <ul style="list-style-type: none">▪ 100% primary care practices are visited and offered data matching during the year.▪ Data match with PIMs once a year		

¹⁴ Cram F. (2014). Improving Maaori Access to Cancer Health Care: Literature Review. Auckland <http://www.katoa.net.nz>: Katoa Ltd.

<p>women who are not attending primary care services (e.g. using the hospital emergency care departments)</p>	
<p>Promotion of BreastScreen to Maaori Women</p> <ul style="list-style-type: none"> ▪ In conjunction with the other Auckland BSA providers, promote the BSA programme at the Maaori Women's Welfare League National Conference in Auckland ▪ Promote the programme through Poukai, Marae, Hapu and Iwi events and other events where high numbers of priority women may attend ▪ Work with Whare Oranga and other Maaori health and social providers to promote the programme to Maaori women <p>Supporting women to screening and assessment services and results clinics</p> <ul style="list-style-type: none"> ▪ Follow up of Maaori women who do not respond to invitation to screening through the generation of DNA/DNR lists ▪ Transport provided to screening, assessment and result appointments ▪ Follow up of Maaori women who are reluctant to attend assessment or results clinics including the provision of support and transport as required <p>Participation in regional planning processes</p> <ul style="list-style-type: none"> ▪ BSCM co-ordinates the development, monitoring and reporting of the regional co-ordination plan ▪ A minimum of 2 regional co-ordination meetings held each year 	<ul style="list-style-type: none"> ▪ Promotion held at MWWL conference ▪ Promotional activities carried out in the community ▪ 100% of Maaori women on DNR lists are followed up ▪ Support and / or transport provided for all Maaori women requiring support ▪ 100% of women referred by breast care nurses who are reluctant to attend clinics are followed up <p>Monitoring Processes</p> <ul style="list-style-type: none"> ▪ Quarterly report to MHAC ▪ Six monthly report to ELT, Board ▪ Quarterly report to MOH outlining: <ul style="list-style-type: none"> ▪ Maaori Coverage levels ▪ Number of practices visited and number of data matches carried out ▪ Number of promotional activities attended, number of participants and number of women enrolled in BSA programme ▪ Number of Maaori women followed up on DNR lists and number subsequently screened ▪ Number of Maaori women followed up who were reluctant to attend assessment and results clinics. ▪ Numbers of Maaori women transported to screening, assessment and results clinics

5.1.7 Tobacco			
<p>Reduce smoking prevalence and smoking related-harm amongst pregnant Maaori women</p> <p>Tobacco use is the leading attributable risk factor to health loss in New Zealand. The prevalence of smoking for Maaori in Counties Manukau is 36 percent compared with 16 percent for the total population. For Maaori in the Northern region, lung cancer is a leading cause of cancer mortality and COPD is a prominent cause of hospitalisation.</p>	<p>Percentage of pregnant Maaori wahine who are smokefree at 2 weeks postnatal</p>	<p>2014¹⁵ Baseline</p>	<p>2016/17 Target</p>
	Maaori	53%	95%
	Total	71%	

¹⁵ Baseline period 1 July – 31 December 2014; this is the most recent data available. Note that this data does not include mothers who do not have a smoking status recorded (approximately 12% of records nationwide). Source: WCTO

Within Counties Manukau, an estimated 51 percent of Maaori women smoke at time of birth. All pregnant women should be referred to stop smoking services as soon as pregnancy is confirmed within a primary care setting or at booking with a midwife. Smoking cessation within 15 weeks gestation reduces all smoking related harm to the baby and mother. Support delivered via specialist stop smoking services is the most effective means of supporting pregnant women to quit.

CM Heath is committed to increasing the quit rates for Maaori women to equal to or greater than the quit rates for the total population and therefore reducing smoking related harm to mothers and babies.

Actions

Smokefree Pregnancy Incentives Programme

- Q1-4: Promote and deliver across South Auckland prioritising high Maaori population areas delivering smokefree services to pregnant Maaori Women and their whaanau (pending MOH agreement with tobacco realignment process)

Referring at time of birth

- Q1-Q4: Implement strategies to ensure all women at time of birth are supported to engage with Smokefree support regardless of whether they managed to stop smoking during pregnancy or not
- Q1-Q4: Implement an alert process that all women who stopped smoking through pregnancy are referred for a follow up conversation to ensure they have continued support post-natal

Collaboration with specialist midwifery teams

- Q1: Identify midwifery specialist teams and midwives working with women postnatal (i.e. diabetes team)
- Q2: Implement strategies to increase referrals for Maaori women finding it difficult to remain Smokefree following birth to achieve equity

Collaboration with maternal mental health

- Q1: Strategize with maternal mental health DHB team most effective ways of supporting smokefree pregnancies and postnatal abstinence

Quickmist/other NRT products provision pilots

- Q1 – Q4: monitor provision and efficacy of Quickmist or any other new non-subsidised products for pregnant and postnatal women. Distributed from primary birthing units and birthing ward at Middlemore hospital if engage with ongoing support

Increase the number of referrals for Maaori wahine, ensuring that there is equal access to care via all midwives

- Q1-4: Address inconsistencies in referrals rates and promote proactive referring

Work force Development

- Q1 – Q4 continue training and upskilling of our midwifery workforce to ensure all are trained to deliver ABC or are aware of how to refer to cessation specialist support
- Q2 develop a workforce training plan in partnership with WCTO providers to ensure all WCTO are trained to deliver ABC or are aware of how to refer to cessation specialist support
- Q2 –Q4 implement actions as per workforce training plan

Collaboration with Well Child Tamariki Ora (WCTO) providers

- Q1: Develop an action plan in partnership with WCTO providers to support postnatal and whaanau smoking cessation or abstinence
- Q2-Q4: Implement actions as per action plan

Engagement with Local Stop Smoking Services

- Q1 –Q2 All service specifications for contracted providers of local stop

Who will we work with?

- Counties Manukau Health DHB employed midwives
- Counties Manukau Health Lead Maternity Carers
- Counties Manukau Health Well Child Tamariki Ora Providers (Plunket, Raukura Hauora o Tainui, Papakura Marae, South Seas)
- Counties Manukau Health SUDI Governance Group

Measures

- Pending MOH agreement, the pregnancy incentive pilot is moved into business as usual and delivered as Smokefree Pregnancy Incentives Programme
- Postnatal referrals to be increased by 25% by Q1, by 50% by Q2, 75% by Q3 and 100% by Q4
- Alert process is developed and implemented by Q2
- Core team of midwifery specialists who work with women postnatal are identified Q1
- Referrals to smokefree services for Maaori women increase
- Action plan initiated with maternal mental health team by Q1
- Action plan implemented Q2-Q4
- Increased provision of Quickmist and any other non-subsidised products for pregnant women
- Ongoing monitoring of referral data by ethnicity
- Increase in numbers of midwives trained in ABC and referral pathways to smokefree services Q1, Q2, Q3, Q4
- Workforce training plan developed in partnership with WCTO Q2
- Action plan developed in partnership with WCTO Q1

smoking services will include clauses and expectations of clear referral pathways for pregnant women and their whaanau, mandatory training on best practice for pregnancy women and their whaanau, clinical supervision for cessation practitioners

- Service specifications are updated to include new clauses and expectations Q1, Q2

Monitoring Processes

- Quarterly review of performance data from MOH and audits of systems other than MMPO (My Practice, Patrac)
- Monthly review of referral rates by ethnicity and referral source
- Monthly monitoring of incentives programme outcomes including 4 and 12 week quit outcomes as defined by National Tier One service specs
- Qualitative analysis from focus groups with clients and midwives scheduled over the quarters.
- Service data from providers working with hapu wahine via monthly reports to the DHB
- Report against each quarter's measures presented to quarterly Smokefree Governance Group meeting
- Quarterly report to MHAC, ELT, ALT

5.1.8 Immunisation

Reduce the prevalence and impact of vaccine preventable diseases in tamariki Maaori

Vaccination can protect newborns and infants from infectious diseases and broader community protection via 'herd immunity'. To ensure that tamariki Maaori have the best start in life and are protected, barriers which impede Maaori newborns and infants having their immunisations on time will be addressed.

With Maaori whaanau and communities CM Health will achieve the target that 95 percent or more Maaori infants have completed their primary course of immunisation on time by 8 months of age¹⁶.

Maaori children have significantly lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases compared with non-Maaori children. Ensuring that vaccination coverage at eight months exceeds the national target is a critical component to enabling Maaori children to achieve the best possible state of health.

Ensuring that parents/caregivers have the right information to make an informed decision and reducing barriers to access are the keys to achieving target immunisation coverage for Maaori Pepe/Tamariki.

Actions

- Q1-Q4: Continue to deliver targeted immunisation strategies to achieve 95 percent coverage for Maaori children for the 8 month and 24 month milestone targets
- Q1-Q4: Monthly monitoring and evaluation of immunisation coverage by DHB National Health Target Working Group (IPIF), and Immunisation Working Group (IWG). These groups will meet monthly to:
 - Continually review and update the immunisation strategies

Percentage of infants who have completed their primary course of immunisation on time by 8 months of age

	2015/16 Baseline Q3	2016/17 Target
Maaori	89%	95%
Total	94%	

Who will we work with?

- Primary Care, Well Child Tamariki Ora Providers, Outreach Immunisation Provider
- Social Sector

Measures

- 85 percent of 6 week immunisations are completed (measured through the completed events report at 8 weeks)
- 95 percent of eight months olds are fully immunised (6 weeks, 3 months and 5 months immunisation events)
- 95 percent of two year olds are fully

¹⁶ Ministry of Health. 2015 (Well Child Tamariki Ora Programme Delivery for 2014). Wellington: Ministry of Health.

<ul style="list-style-type: none">▪ Work with Primary Care to increase GP practice immunisation hours to reduce barriers to access, all day weekday service, twilight, weekends▪ Monitor and evaluate immunisation coverage at DHB, PHO and Practice level, manage identified service delivery gaps▪ Drive service changes within the sector <ul style="list-style-type: none">▪ Q1-Q4: CM Health representation and attendance at Regional and National immunisation forums▪ Q1-Q4: Prioritisation of Maaori Pepe and Tamariki for immunisation and/or outreach Immunisation services▪ Q1-Q4: Immunisation Nurse Leader to work with all practices with low Maaori and high needs coverage rates and meet individually with each practice to improve performance measured by the datamart report in the following month▪ Q1-Q4: Implement ‘milestone’ immunisations alerts for high risk Pepe/Tamariki to prompt on-time immunisation or early referral to outreach immunisations▪ Q1–Q4: Active follow up on declines by Immunisation Nurse Leader to provide additional information to parents and whaanau on the benefits of immunisation and to address any concerns and questions▪ Q1: Improve processes to enable faster turnaround of overdue reports and earlier referral to Outreach Immunisations▪ Q1-Q4: Increase newborn enrolment rates:<ul style="list-style-type: none">▪ Q1- Q4: Continue working with Maternity, Well Child Tamariki Ora and Primary Care partners to monitor the newborn enrolment rates▪ Q1-Q4: Work with primary care to establish a process to ensure all newborn enrolments are accepted or faster decline for reallocation;▪ Q1-Q4: WCTO monitor of enrolment with GP at core contact 1, and check at every core contact on immunisation milestones▪ Refer Access to Care section 5.1.3▪ Q1–Q4: Develop a joint immunisation communications plan with primary care and NGO sectors to include various promotional activities e.g. radio talk-back interviews, local papers, reminder cards, PHO incentives▪ Q3-Q4: Actively promote and participate in ‘Immunisation Week’▪ Q2: Review health literacy of immunisations communications▪ Q2-Q4: Work with intersectoral partners to identify and refer families who are not currently engaged with health services outreach immunisation providers	<p>immunised</p> <ul style="list-style-type: none">▪ Coverage rates for Maaori equal to non-Maaori▪ 90 percent of 4 year olds are fully immunised before their 5th birthday								
<p>Reduce the prevalence and impact of seasonal influenza in vulnerable Maaori aged 65+</p> <p>Influenza can have significant complications for the population aged 65 years and older, which can result in hospitalisation, significant morbidity, and mortality.</p> <p>In 2014 Maaori nationally had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU.</p> <p>A 75 percent influenza vaccination rate is required to provide the best protection for this age group and in particular for Maaori. In Counties Manukau, only 66 percent of those aged over 65 years were immunised against influenza in 2014/15.</p>	<table><tr><td>Percentage of the eligible population 65 years and over who have had a seasonal influenza vaccination</td><td>2015/16 Baseline Q2</td><td>2016/17 Target</td></tr><tr><td>Maaori</td><td>66%</td><td rowspan="2">75%</td></tr><tr><td>Total</td><td>67%</td></tr></table> <p>Who will we work with?</p> <ul style="list-style-type: none">▪ CM Health PHOs <p>Monitoring Processes</p> <ul style="list-style-type: none">▪ Quarterly reporting to Maaori Health Advisory Committee (MHAC), Executive Leadership Team (ELT) and Alliance Leadership Team (ALT)	Percentage of the eligible population 65 years and over who have had a seasonal influenza vaccination	2015/16 Baseline Q2	2016/17 Target	Maaori	66%	75%	Total	67%
Percentage of the eligible population 65 years and over who have had a seasonal influenza vaccination	2015/16 Baseline Q2	2016/17 Target							
Maaori	66%	75%							
Total	67%								

Actions	Measures
<p>Promote and provide free seasonal flu vaccinations, to those aged 65 and over</p> <ul style="list-style-type: none"> Q1-Q4: Support PHOs to report and monitor flu vaccination rates for people aged 65+ by ethnicity to focus on uptake by Maaori Q2: In partnership with the Maaori Health Gains Team, develop a targeted seasonal influenza communications plan to promote the benefits of the seasonal influenza immunisation and encourage Maaori aged 65+ to be immunised Q3-4: Implementation of targeted communications plan Q3-Q4: During flu season ensure that PHOs are actively promoting flu vaccinations and are targeting communications at the eligible population Q1: Trial use of pharmacies to provide funded seasonal influenza vaccine to Maaori aged over 65 years Q1: Delivery of locality programmes to reach vulnerable groups including Maaori aged over 65 years 	<ul style="list-style-type: none"> Q1-Q4: 75% of Maaori aged over 65 receive free flu vaccinations

5.1.9 Rheumatic Fever

Reduce rheumatic fever rates in tamariki Maaori and whaanau	Acute rheumatic fever first hospitalisations rates per 100,000 population	2015/16 Baseline ¹⁷	2016/17 Target
<p>CM Health has the highest number of rheumatic fever notifications in comparison to all DHBs, and has an overall rheumatic fever rate of 8 per 100,000 population.</p> <p>There has been a large investment by CM Health in our Rheumatic Fever Prevention Plan with the aim to reduce the incidence of rheumatic fever among all tamariki in Counties Manukau</p>	Maaori	8.5	- ¹⁸
	Total	6.0	4.5
Actions	Measures	Reporting	
<p>Deliver activities and actions as per refreshed CM Health Rheumatic Fever Prevention Plan. This plan can be found at: http://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/2013-2017-Rheumatic-fever-prevention-plan.pdf</p> <ul style="list-style-type: none"> Q1-Q2: As per agreed business case, implement changes to school based programme: <ul style="list-style-type: none"> Contract services to new/existing providers Modification to model in 61 of schools Integration of the school based programme with existing CM Health integration strategies including the At Risk Q1: Work with PHOs and GP practices to identify and implement a service improvement approach to sore throat clinics in primary care Q1-Q2: Work with secondary schools on a sustainable service delivery model for sore throat clinics in schools Q1-Q2: Trial alternative options (TBC -Pharmacy, Dental Clinics, B4SC) for sore throat clinics Q1: Update the CM Health communication strategy and ensure alignment with the metro Auckland regional plan and the annual Winter awareness campaign Q2: Develop a local health promotion calendar to drive the activity from the communication strategy Work with the secondary and primary care to ensure families with 	<ul style="list-style-type: none"> 100% participation by eligible schools within the programme Sore throat clinics continued in 100% of decile 1-3 secondary schools 100% eligible patients referred to AWHI 	<ul style="list-style-type: none"> Delivery and reporting of endorsed Rheumatic Fever Prevention Plan each quarter. This includes actions to: <ul style="list-style-type: none"> Increase awareness of rheumatic fever, what causes it and how to prevent it Prevent the transmission of Group A streptococcal throat infections within households Treat Group A streptococcal throat infections quickly and effectively 	
	Monitoring Processes		
	<ul style="list-style-type: none"> Monthly updates to CPHAC Quarterly reporting to MHAC and MOH 		

¹⁷ Source of baseline data: MOH incidence of first episode acute rheumatic fever cases as defined by MOH algorithm for the 2015 calendar year. Rate per 100,000 population based on Statistics NZ estimated resident population projections.

¹⁸ No target for Maaori, total population target only

children at high risk of rheumatic fever (defined as Quintile 5, Maaori and/or Pacific) living in crowded housing with 100 percent being referred to Auckland Wide Housing Initiative (AWHI)

- Work collaboratively with primary and community service partners to develop systems that ensure that people with Group A strep have begun treatment as soon as possible or feasibly practical
- Continue to work with secondary care to ensure notification of acute rheumatic fever to the Medical Officer of Health occurs within 7 days
- Secondary care clinicians will review cases of rheumatic fever to identify risk factors and system failure points
- Work with primary care to understand the number of people receiving prophylaxis through General Practice rather than through community nursing services
- Q1: Follow-up on any issues identified in the 2015/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic heart disease
- Undertake an annual audit of rheumatic fever secondary prophylaxis coverage for children aged 0-15, 15-24 and adults 25 years+. Annual audit of rheumatic fever secondary prophylaxis coverage is reported in Q4
- Q2: Confirm funding investment plan for rheumatic fever prevention

Who will we work with?

- Ministry of Health
- PHOs
- Primary Care
- Maaori Health Providers
- Pacific Health Providers
- Northern Region DHBs
- Ministry of Education
- Ministry of Social Development
- Housing providers (AWHI, Warm up Counties)

5.1.10 Oral Health

Increase early detection and intervention for improved oral health among tamariki Maaori

Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

Tamariki Maaori are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and better target those most in need.

The aim of the community oral health service is “every child is able to enter adulthood pain free, disease free, with functional dentition and positive dental self-esteem”.

Improving access and barriers to good oral health and dental care for Maaori infants will address current dental and oral health inequalities for this population and support them to have a good start in life.^{19,20}

Percentage of preschool children 0-4 years enrolled in the community oral health service

	2015/16 Baseline	2016/17 Target
Maaori	66.7%	95%
Total	74.1%	

Who will we work with?

- Auckland Regional Dental Service (ARDS)
- Auckland Oral Health Regional Services
- Mighty Mouth Dental (Preschool Toothbrushing program)
- Well Child Tamariki Ora providers

Monitoring Processes

- Monthly COHS referrals and enrolment reports
- Six monthly WCTO indicator reports
- Six monthly regional reports
- Quarterly reporting to MHAC, ELT and ALT

¹⁹ Rothnie, J.J., W. M. (2012). An exploratory study of pregnant women's knowledge of child oral health care in New Zealand. NZ Dent.J., 108(4) 129-33.

²⁰ Kilpatrick NM, G. M. (2008). Maternal and Child Oral Health- Systematic Review and Analysis; A report of the New Zealand Ministry of Health. Children's Research Institute.

Actions

- Q1: Implementation of enrolment by 5 months into COHS by Well Child Tamariki Ora Providers
- Q1-Q4: Clinical examination of tamariki by 1 year of age
- Q1-Q4: Preschool examinations use a flexible model for better access, engagement and attendances:
 - Dental therapist specific screening time at a Well Child Tamariki Ora clinic –use a smaller screening van and/or portable equipment; specific weekdays and possible Saturdays to catch the working parents or
 - Larger preschools – using screening van and/or portable equipment or
 - At the COHS dental clinics/ mobile vans/ TDUs
- Q1: Pilot increased access hours for hub dental clinics through a Saturday trial at Browns Road Hub Clinic for preschoolers to reduce barriers to access and increase appointment capacity
- Q1–Q4: Provide incentive welcome packs for children aged 1 year for their first examination
- Q1–Q4: Oral Health education is provided to parents and caregivers by WCTO Providers at all core contacts, and includes Lift the Lip exam, advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments
- Q1-Q4: Follow-up of persistent DNAs in preschool patient group through WCTO, PHN or community health workers
- Q1-Q4: Monitoring of preschool children identified with severe Early Childhood Caries identified at dental examination or referred to hospital dental services for extractions under general anaesthetic
- Q3-Q4: Local promotion of swap sugar sweetened drinks to water or milk as part of oral health literacy promotion
- Q3-Q4: Review Preschool Mighty Mouth tooth brushing programme to expand from 150 high needs / high Maaori and Pacific preschools to an additional 80 identified preschools
- Q1: Child Health Services multi-enrolment / referral flyer includes preschool oral health checks with Well Child Tamariki Ora Providers

Measures

- 95% of eligible children 1 year of age are enrolled in COHS
- 95% of eligible children 1 year of age are examined by a dental therapist

5.1.11 Mental Health

Reduce health disparity for Maaori with regards to the use of Mental Health Act: Section 29 Compulsory Treatment Orders.

There is a pressing need to address and reduce the health disparity for Maaori with regards to the use of Community Treatment Orders (CTO). In 2015/2016 CM Health completed an audit of Maaori service users on a s.29 Indefinite CTO and updated procedures to support compliance and timeliness of Mental Health Act reviews.

The audit identified both system and patient factors that contribute to the likelihood of a Maaori service user remaining on a s.29 indefinite CTO.

In 2016-2017 we will build upon prioritised areas for improvements.

Mental Health Act: Section 29 Indefinite CTO rates per 100,000 population		2015/16 Baseline	2016/17 Target
	Maaori	132 per 100,000	21
	Total	50 per 100,000	

Who will we work with?

- Service users, whaanau, NGOs, primary care, Specialist Mental Health services, Mental Health Act officers and administrators

Monitoring

- Quarterly report to MHAC, ALT and ELT

²¹ No targets set by MOH for 2016/17

Actions	Measures
<p>Initiative 1: Enhance workforce capability Improve workforce awareness and practices with regard to application for and release from the Mental Health Act 1992: Section 29 Indefinite orders. This will be achieved by delivering workforce training that reinforces but also enhances the workforce knowledge and awareness about the use of indefinite CTOs and reflects on what they could do to support Service users recovery and release from an indefinite CTO.</p>	<p>Q1: Each adult community MH team undertakes audit of staff identified needs for further CTO training</p> <p>Q2: Review and update Mental Health and Addictions training programme for SMO's, Mental Health Clinicians, administration staff where appropriate</p> <p>Q3: Commence in-service training updates on CTO for adult community Mental Health teams</p> <p>Q4: Complete and evaluate in-service training updates on CTO for adult community MH teams</p>
<p>Initiative 2: Implement improved systems for CTO clinical reviews: Ensure 95% of service users on a s.29 Indef CTO have a timely clinical review by:</p> <ul style="list-style-type: none"> ▪ Undertaking a systematic improvement of the processes of information flow between clinical teams and the Mental Health Act Officers and administrators ▪ On-going regular monitoring of the KPIs by the Mental Health Clinical Director and the Director of Area Mental Health Services 	<p>Q1: Agreed a plan for the systematic improvement across the Mental Health Division</p> <p>Q2: Implement plan</p> <p>Q3: Monitor, and refine operations as necessary</p> <p>Q4: Have reached 95% target of service users on indefinite CTO have had a timely clinical review</p>
<p>Initiative 3: Improve consultation/engagement with whaanau for service users on CTOs Improve consultation/engagement with whaanau to enhance service user recovery.</p> <p>Improve ability to be released from a CTO by understanding the factors that prevent whaanau consultation and engagement with the responsible Clinician undertaking the Mental Health Act clinical review.</p> <p>Develop a plan to improve the proportion where the consultation engagement is routinely undertaken</p>	<p>Q1: Consult with whaanau to understand their consultation/engagement needs</p> <p>Q2: Have undertaken work to better understand the factors that prevent whaanau consultation and engagement with the Responsible Clinician undertaking the Mental Health Act clinical review</p> <p>Q3: Develop targets and reports to monitor levels of consultation/engagement</p> <p>Q4: Have developed an action plan to improve the levels of consultation/engagement with whaanau for service users on an indefinite CTO</p>

5.1.12 Sudden Unexpected Death in Infancy (SUDI)				
<p>Reduce SUDI rates in Maaori infants</p> <p>Sudden Unexpected Death in Infancy (SUDI) is the leading cause of preventable post-neonatal death in infancy. Maaori infants are 5 times more likely to die than non-Maaori infants in New Zealand, with around 40 SUDI deaths among Maaori per year.</p> <p>These deaths can be prevented through access to a safe sleep space, smoke free pregnancy and environment, placed on back to sleep, and breastfeeding.</p> <p>Our 2016/17 objectives are to:</p> <ul style="list-style-type: none"> ▪ Reduce SUDI rates in Maaori infants through improved knowledge attitudes and behaviours to reducing SUDI risk factors ▪ Facilitate community and intersectoral linkages through monthly Safe Sleep Champion meetings, and annual Community Network hui ▪ Facilitate education through health and community organisations, and 	SUDI deaths per 1,000 live births		2010-14 Baseline ²²	2016/17 Target
		Maaori	2.13 (1.38 – 3.14)	0.4
		Total	0.96 (0.69 – 1.30)	
	Percentage of caregivers provided with	Maaori	58%	100%

²² Five year annualised data. Source: MOH

<p>engagement with community events e.g. Waitangi Day Manukau and Safe Sleep day</p> <ul style="list-style-type: none"> Facilitate access to safe sleep devices for babies in unsafe sleeping environments Promotion of pregnancy and parenting education opportunities with Maaori whaanau incorporating key SUDI messages and support services <p>CM Health SUDI strategy is aligned to the Northern Region SUDI 5 year Action Plan.</p>	SUDI prevention information at WCTO Core Contact 1	Total	62.7%	
<p>Actions</p> <p>Safe Sleep Policy & Audits</p> <ul style="list-style-type: none"> Q1-Q4: Safe sleep policy in place to cover all maternity, newborn, and infant environments, including antenatal and postnatal care in the community and hospitals, all maternity environments including delivery suites and birthing units, neonatal and inpatients units and ED Q1-Q4: Monthly safe sleep audits are completed and documented by all maternity wards and primary birthing units <p>Workforce Knowledge and Development</p> <ul style="list-style-type: none"> Training of all child health and maternity staff around safe sleep and SUDI prevention on induction and then at regular intervals All child health and maternity related external contracts to include training around SUDI prevention as a requirement of workforce <p>Improve access to and engagement in antenatal and early parenting education (which incorporates safe sleep practice, breastfeeding and smoke free health literacy)</p> <ul style="list-style-type: none"> Q1: Implement a revised antenatal and parent education curriculum with a focus on Maaori, Pacific and teen pregnant parents Q1: Implement and evaluate (Q3) the community based SUDI initiative “Whānau Hapu Waananga” with a focus on engaging with Maaori women and whaanau <p>Increase early engagement and enrolment with LMC and WCTO</p> <ul style="list-style-type: none"> Q1-Q4: Implement the ‘High Five New Born Enrolment Initiative’ referring and enrolling newborns at birth with GP, National Immunisation Register (NIR), Well Child Tamariki Ora (WCTO), Hearing and Vision and Community Oral Health Service (COHS) Q1-Q4 Increase the number of women who register with an LMC in their first trimester of pregnancy through: <ul style="list-style-type: none"> GP referral pathways to encourage early referral before 10 weeks gestation to a midwife or LMC Appointment of LMC midwives to support navigating women seeking midwifery care LMC Liaison midwives involved in attracting and retaining LMC midwives in Counties Communication and referral system in place for women to have their details sent out to an LMC midwife who then accepts the referral and contacts the woman GP referral pathways for pregnant women to provide a consistent approach in primary care to cater for women who reside in one area but choose to birth in another Q1-Q4: Increase early enrolment and engagement with WCTO Q1-Q4: Increase number of Maaori infants receiving WCTO Core contact 1 Q1-Q4: Increase number of Maaori caregivers receiving safe sleep information at WCTO Core contact 1 Increase new born PHO enrolment rates – refer section 5.1.2 				

SUDI Risk Assessment Tool

Primary Care

- Q1: Using the findings from the primary care pilot, modify the SUDI Risk Assessment Tool for use in primary care practice management systems
- Q1-Q4: Phased roll out and implementation of SUDI Risk Assessment Tool in primary care. Risk assessment screening and provision of safe sleep information for every infant at 6 week immunisation

Midwives

- Q2: Review findings from the midwifery pilot and develop implementation plan for roll out
- Q3: Roll out and implementation of SUDI Risk Assessment Tool

Research

- Q4: Repeat David Tipene-Leach study in Counties Manukau with 200 Maaori and 200 Pacific mothers and whaanau

Safe Sleep Programme

- Q1-Q4: Delivery of regional Safe Sleep Programme:
 - Provide safe sleep baby bed to whaanau identified as requiring access to a safe sleep space for their infant
 - Q1-Q4: Referral pathway in place for LMC to refer whaanau identified as requiring access to safe sleep baby bed
 - Q2: Development of referral pathway for WCTO Providers to refer whaanau identified as requiring access to safe sleep baby bed
 - Q3: Identify and train 3 WCTO providers, LMCs, DHB Community Midwives and other social sector agencies to be distributors of safe sleep baby beds

Activities to Support reduction of SUDI Risk factors i.e. P.E.P.E.:

PLACE baby in own baby bed, face clear of bedding; POSITION baby on back face upward

- Q1-Q4: The safe infant sleep environment will be assessed and planned during every pregnancy and for all newborn infants and safe sleep information provided in late pregnancy, in first week of baby being born and at WCTO core contact 1. Families assessed with unsafe infant sleep environments will be referred to Safe Sleep Team to receive additional support to reduce the risk of SUDI.

ELIMINATE smoking in pregnancy & protect baby with smokefree whaanau, whare & waka

- All pregnant women who smoke are offered brief advice and support to quit
 - Delivery of Smoking Cessation in Pregnancy Plan
 - Ongoing monitoring of mandatory alert of smoking in pregnancy at midwife booking interview or admission to maternity facilities and referral to Smoking Cessation Services for follow-up
- Smoking cessation support will be offered to all mothers, fathers, and whaanau who smoke, with referral to a culturally appropriate smoking cessation service
- Reduce smoking prevalence and smoking related-harm amongst Maaori - refer section 5.1.7 of this document and section 2.2.5 of the CMDHB Annual Plan

ENCOURAGE and support mothers to breastfed

- Increase the percentage of Maaori infants breastfed – refer section 5.1.4

- SUDI Risk Assessment Tool implemented

- Research findings

- Referrals to Safe Sleep Programme
- Referral pathways in place
- Providers identified and trained

- Infant sleep environment assessed during every pregnancy
- All caregivers provided with SUDI prevention information at WCTO Core Contact 1
- Referrals to Safe Sleep Programme

- Referrals to Smoking Cessation and utilisation of pregnancy incentive programme

- 75% exclusive or fully breastfed at LMC discharge
- 60% exclusive or fully breastfed at 3 months
- 65% receiving breast milk at 6 months

6.0 Local Indicators

6.1.1 Workforce Development

CM Health has the largest Maaori and Pacific population in New Zealand. The relatively youthful population reflects a significant labour market opportunity if barriers to educational achievement can be addressed. Counties Manukau Health is a significant employer in South Auckland.

Increasing Maaori health workforce participation rates is fundamental to improving the quality and effectiveness of care. A highly trained and robust Maaori (and non-Maaori) health workforce will better enable us to meet the needs of our diverse communities and populations.

There is evidence that a 'pipeline' or student driven approach to workforce development and implementing evidenced-based interventions to overcome barriers to workforce participation will enhance graduate success. Barriers need to be reduced and innovative ways established to make it easier for more Maaori to walk through the door and into employment in the health and disability sector.

What are we trying to do?

Increase the number of Maaori in the CM Health health and disability workforce everywhere from 6% to 16% by 2020.

The Counties Manukau DHB vision is to develop the local workforce to serve the health needs of its community and reflect the diversity of the area. When compared to the resident population, Maaori make up 16.3 percent of the population serviced by CM Health with 7.1 percent of employees identifying as Maaori, a variance or gap of 9.2 percent (Table 5).²³ This means that the current number of Maaori employees would need to **treble** to reflect the estimated population today.

	Maaori	Pacific
% of workforce (HC)	7.1%*	10.2%
CMDHB population	16.3%	23.1%
Variance	-9.2%	-12.9%

Table 5: Ethnicity of workforce by headcount compared to CMDHB population in 2014

Progress has been slow with an increase of 42 employees who identify as Maaori between 2011 and 2015 (Table 6).

	2011		2015		
Ethnicity	HC	HC %	HC	HC %	Variation
Maaori	373	5.7	415	5.6	42
Pacific	627	9.6	823	11.1	196
Other	5553	84.7	6152	83.2	599
Total	6553	100%	7390	100%	837

Table 6: CM Health Workforce Reports, 2011 and 2015

To put this goal in context this means increasing the CM Health workforce by 10 percent or over 150 new Maaori employees each year (Graph 1). This projection does not include any adjustment for turnover or changes in the size of the total CM Health workforce.

Percentage of Counties		2015/16 Baseline	2016/17 Target
Manukau DHB who are Maaori by HC	Head Count	415 ²⁴	570
(155 new Maaori employees/yr)	Head count %	6	7.7

Who will we work with?

Improvement in workforce disparities takes time, and requires leadership and commitment from a range of stakeholders. To achieve our objectives we will work with:

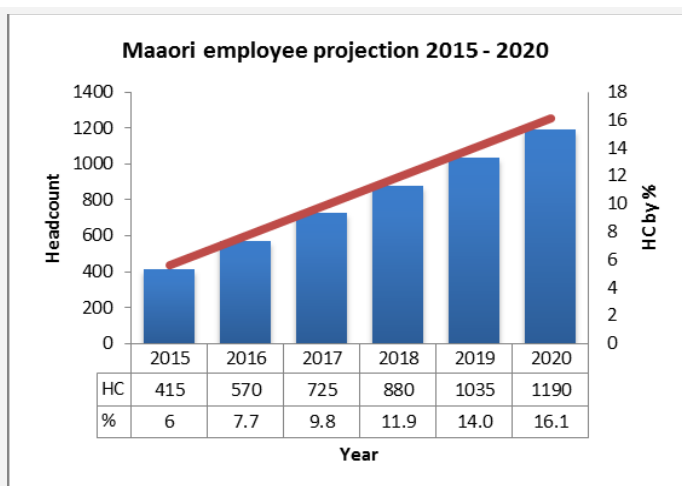
- Taura and their whaanau who are interested in a career in health
- Secondary schools in Counties Manukau
- Tertiary education providers including Joint Venture Partners the Manukau Institute of Technology, Auckland University of Technology and University of Auckland
- Professional/ clinical leaders, clinical educators, HOD's and school/ faculty staff
- Auckland DHB and Waitemata Maaori and Pacific workforce teams
- External funders including the Tindall Foundation
- CM Health Recruitment Centre team, HR staff and Communication team
- PHOs, Maaori providers/NGOs and Primary Care providers
- CM Health clinical teams and services including the Volunteer Service

Monitoring Processes

- Monthly review of CM Health workforce metrics
- ELT
- MHAC
- Mana Whenua Board meetings
- Tindall Foundation Steering Group
- Ministry of Health (as per contract requirements)
- Northern Regional Alliance (NORTH)

²³ Note the estimate of 7.1% in 2014 is higher than the 5.6% reported in 2015.

²⁴ 423 in November 2015.



Graph 1: Maaori employee projection 2015 – 2020

To achieve this level of scale will require a refreshed workforce strategy that will focus on increasing workforce (graduate) supply; implementing effective recruitment and talent sourcing approaches; and attention to job creation and innovative models of employment.

Actions

To accelerate Maaori workforce development in CM Health we will:

Develop and implement a robust performance monitoring system that will enable accurate reporting of Maaori health workforce results. This will include but not be limited to:

- Q1: Implementation of an online registration process and single database to track, monitor and report on all tauira (students) who engage in any CM Health workforce programmes.
- Q1-4: Monitoring and reporting on the number of Maaori job applicants; applicants taken to interview; applicants offered employment and new hires
- Q2: Auditing and improving the process for the collection, analysis and reporting of CM Health employee/workforce ethnicity data
- Q1-4: Track and monitor Maaori staff turnover and reasons for exit to inform retention strategies.

Review the current 'end to end' recruitment pathway (including marketing, sourcing, applicant selection and appointment) and associated Human Resource policies, processes and procedures to identify barriers and/or implement measures to ensure more equitable employment outcomes for Maaori²⁵. This will include but not be limited to:

- Q1: Auditing CM Health's compliance with Good Employer obligations²⁶
- Q1-4: Work with Human Resource team to revise policies and implement values-based recruitment organisation-wide
- Q1: Review of the NETP (new graduate nurse) recruitment process and candidate assessment model
- Q2 – Q4: Expansion of the CM Health cadetship and internship programmes.
- Q1-4: 38-40 new hires who identify as Maaori each quarter (155/pa)

Measures

Accurate workforce data is essential for planning and assessing performance. Currently a range of workforce metrics are already reported by the HR team regarding the CM Health workforce. These include data on:

- CM Health workforce demographics (age, gender, ethnicity by FTE and Headcount)
- Workforce indicators: employment status, role/role category, turnover, length of service etc.
- Recruitment indicators: new job applications; applications reviewed; applicants interviewed; applicants hired including data on new graduate nurse applications via the Advanced Choice of Employment (ACE) scheme

The data reported by HR will be used to measure performance and the impact of workforce interventions over time. In addition, data that will track tauira through the pipeline will be reported.

²⁵ Both the Human Rights Act 1993 and the New Zealand Bill of Rights Act 1990 recognise that to overcome discrimination positive (or restorative) actions may be needed to enable particular groups to achieve equal outcomes with other groups in our society. These actions are not discriminatory if they assist people in certain groups to achieve equality. Any special measure must be based on information that shows that the present position is unequal.

²⁶ District Health Boards (DHBs) have obligations as employers; these are set out in Section 22 (1)(k) of the New Zealand Public Health and Disability Act 2000 and as defined under Section 6 (1) of the NZPHD Act and under Section 118(2) of the Crown Entities Act 2004 (CE Act) in other legislation, and in government statements. Under Section 118 of the CE Act, a DHB is required to operate a policy that complies with the principles of being a good employer and make that policy (including the equal employment opportunities programme [EEO]) available to its employees and ensure its compliance with that policy and EEO programme). Compliance with these principles are reported in the DHB's Statement of Intent and Annual Report.

Implement an integrated rangatahi programme aimed at increasing the number of Maaori recruited into tertiary level health programmes. This will include but not be limited to:

- Q1: Regional alignment with ADHB and Waitemata DHB Rangatahi Programme activity
- Q1: Integration of all school-based and CMH-based workforce activity offered under existing workforce programmes
- Q1-4: 200 new Maaori students participate in programme activity each year
- Restart the Pu Ora Mataini nursing programme to include a focus on increasing the supply of Maaori registered nurses, enrolled nurses and health care assistants into the CMH and primary care workforce

Develop a Leadership Development Programme to strengthen Maaori clinical leadership and management capability. This will include but not be limited to:

- Q1: Identifying and promoting existing leadership development programmes
- Q2 – 4: Creating learning opportunities to share and implement best practice in terms of indigenous health excellence
- Q2-4: 6-8 Maaori staff undertake dedicated leadership development programme

In partnership with clinical leaders, educators and senior managers, develop and implement a cultural competence programme that improves the skills, knowledge and ability of the wider workforce to engage with and improve the quality of care provided to Maaori whaanau

- Q1-2: Scope options for delivering a programme to the entire CMH workforce
- Q2-4: Design and implement programme
- Q3-4: 80 percent of all new hires complete any mandatory programme requirements
- Q1-4: Work with HR team to implement values-based recruitment organisation-wide

6.1.2 Rangatahi Mental Health

Improve and preserve the mental wellbeing of rangatahi Maaori

CM Health is taking a broad strategic approach to the planning of youth mental health services for rangatahi Maaori.

Actions align with broader DHB youth, mental health and primary care objectives and with the Prime Minister's Youth Mental Health project. The focus for rangatahi Maaori will be on:

- Ensuring school-based health services are widely available to all eligible rangatahi Maaori
- Improving access to primary mental health and alcohol brief intervention services in general practice, as well as a focus on 'youth friendly' primary care
- A focus on reducing disparities between Maaori and non-Maaori using the primary care-based Chronic Care Management (CCM) Depression programme as a platform

Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)		2015/16 Baseline Q2	2016/17 Target
	Maaori	0.3%	0.5%
	Total	0.3%	
Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)			
	Maaori	0.2%	0.4%
	Total	0.1%	

Actions

School Based Health Services (SBHS) – PP25 Initiative 1

- Review the provision of school-based health services for rangatahi Maaori in local kuras

Measures

- Offer SBHS to two additional kuras by Q2
- 95% of eligible rangatahi Maaori will have SBHS assessment by Q2

<ul style="list-style-type: none"> Ensure that 95% of Maaori students eligible for a routine health assessment (which includes a HEEADSSS assessment) receive an assessment 	
Youth Primary Mental Health- PP26 Initiative 3 Improve the responsiveness of primary care to youth – PP25 Initiative 5 <ul style="list-style-type: none"> Increase the number of rangatahi Maaori accessing Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions Work closely with general practice teams who have linkages with schools to ensure they are 'youth friendly' by introducing an appropriate audit tool and appointing a Primary Care Youth Health Quality Advisor to assist practices with implementing the agreed actions following the assessment 	<ul style="list-style-type: none"> Increase in access to Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions by the end of Q4 Primary Care Youth Health Quality Advisor to complete PSDA cycle with 25 practices by the end of Q4
Improve and preserve the mental wellbeing of rangatahi Maaori with a focus on depression The aim for mental health in primary care for 2016-17 is to reduce the disparity between Maaori and non-Maaori in the Chronic Care Management (CCM) Depression programme. Following the 2015-16 information gathering and discussion with stakeholders including primary and secondary care, it is proposed that the following actions be implemented in 2016-17: <ul style="list-style-type: none"> Partnering with Maaori providers including Te Ara WhiriWhiri (Maaori mental health collective) Programme monitoring on a monthly basis with programme KPIs reported by ethnicity with a particular focus on patient engagement KPIs Working to deliver group based CBT with potential for a rangatahi Maaori-tailored group 	<ul style="list-style-type: none"> By Q2, partner with Te Ara WhiriWhiri Monthly monitoring of KPIs via the CMM Depression Clinical Governance Group (commencing Q1) Delivery of group-based CBT tailored for rangatahi Maaori by Q4
Who will we work with? <ul style="list-style-type: none"> Primary Mental Health Co-ordinators, PHOs & Primary Care Clinicians Primary Care Youth Health Quality Advisor School Nurses & School Guidance Counsellors Whirinaki, particularly the school-based Mental Health Clinician & He Kākano CCM Depression Clinical Governance Group 	

6.1.3 Cardiovascular Disease Risk Assessment and Management

Improve early detection and management of CVD amongst Maaori			2015/16 Baseline	2016/17 Target
Background Cardiovascular Disease (CVD) is the leading cause of death in CM Health. People with CVD and diabetes are associated with high level of health care costs and have a significant impact on the health and social and economic wellbeing of Maaori individuals and whaanau. In 2008, Maaori had the highest age standardised CVD prevalence compared to other ethnic groups in the CM Health district. Focus on the prevention and cardiovascular disease, screening for CVD risk and appropriate management of CVD, including diabetes and alongside other chronic health conditions as gout is important for Maaori.	Percentage of eligible population who have had their cardio-vascular risk assessed in the last five years	Maaori	88.1%	90%
		Total	92.1%	
Rationale The burden of cardiovascular disease (heart and stroke) is greatest among the Maaori population, and mortality is more than twice as high compared to non-Maaori. CVD risk assessments are an important tool to enable early identification and management of people at risk of heart disease and diabetes. Fast access to treatment for heart related attacks is essential to achieve health equity and improve health outcomes for Maaori.	Percentage of eligible population who have a risk greater than 20%	Maaori	²⁷	TBC
		Total		

²⁷ Baseline to be established in 2016/17

Actions and Milestones to improve CVD Risk Assessment rates for Maaori <ul style="list-style-type: none">Q1: Creation of regular monthly reports on Maaori who have not yet had a risk assessment or who need to be recalled as their last risk assessment was five years ago.Q1: Establish new reports for Maaori men turning 35, and Maaori women turning 45 within the next three months to proactively target these groups for a risk assessmentQ2: Work closely with marae and churches who have linkages with primary care to encourage Maaori and Pacific patients to have a CVD risk assessment with appropriate follow upQ1: Utilisation of electronic decision support tools to ensure Maaori receive evidence based careQ1: Offering phlebotomy or point of care testing to Maaori in practiceQ1: Subsidised or free CVD Risk Assessment appointments for Maaori by some PHOsQ1: Ensure Maaori have access to appropriate resources such as The Heart Age Forecast (www.knowyournumbers.co.nz)Q1: Utilisation of test safe data to complete non face-to-face CVD risk assessment within all PHOs and recall high risk Maaori for managementQ2: Investigate workplace risk assessment opportunities and complete a cost/benefit analysis	Percentage of eligible population who have a risk greater than 20% and are on dual therapy	Maaori			
		Total	28	70%	
	Who will we work with? <ul style="list-style-type: none">Northern Region Cardiac NetworkPrimary Care and Secondary Care clinicians and Clinical ChampionsIntegrated Care Clinical Governance GroupCM Health IPIF Working Group				
	Monitoring Processes <ul style="list-style-type: none">Monthly CVD risk assessment data from to DHB by ethnicityWeekly monitoring at PHO level of practice performanceMonthly DHB & PHO level data evaluationMonthly reporting to CPHAC, ELT and BoardQuarterly reporting to MOHMonitoring of DHB performance by Northern Region Cardiac Network				
	Measures <ul style="list-style-type: none">Percentage of eligible Maaori population who have a risk greater than 20% and are on dual therapy				
	Actions and Milestones to improve CVD Management for Maaori <ul style="list-style-type: none">Q1: Active recall of all Maaori with a CVD risk >10% by text and phone callsQ2: Complete a stocktake of all exercise and nutrition programmes for Maaori and ensure referral pathways are in place from primary care for eligible Maaori who have a CVD risk >5%Q1: Maaori with a CVD risk >20% will be prescribed dual therapyQ1: Maaori with a low to high risk will be offered a referral to a culturally appropriate Self-Management Education groupQ2: Primary and Secondary care clinicians will work together in multi-disciplinary teams to manage patients with a >20% riskQ1: Development and/or utilisation of culturally appropriate resources such as ‘know your numbers’, and the healthy heart visual food guide in te reo MaaoriQ1: Shared management decisions based on discussions between clinicians and Maaori at high risk of CVDQ1: Address transport barriers and time barriers by offering support with accessing primary care through the provision of weekend and after-hours clinicsQ2: Implementation of communication training for primary care staff to support trusting and effective relationships including patient led decision making and goal setting				

²⁸ Baseline to be established in 2016/17

6.1.4 Diabetes Management

Background

Diabetes is a long term condition that leads to increased rates of morbidity and mortality in the condition is not well managed. CM Health has the largest number of people in the country with diabetes, with over 40,523 people recorded as having diabetes in 2014.

Prevalence, morbidity and mortality rates from diabetes are higher for Maaori than other groups, therefore targeted initiatives are required to reduce the prevalence of risk factors for the development of diabetes and to improve identification, screening and management of diabetes, particularly to achieve good glycaemic control.

We will redesign the Diabetes Care Improvement package to focus on those who have poor glycaemic control by actively identifying this group of people and following a virtual review implementing a range of interventions, including those provided by the At Risk programme.

Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance which will be improved through application of a collaborative approach with a new targeted model of care for those practices that have high numbers of patients with poorly controlled diabetes.

		2015/16 Baseline	2016/17 Target
Percentage of population who have an HbA1c less than 64mmol/mol	Maaori	60%	69%
	Total	58%	
Percentage of people with diabetes with an up to date retinal screen	Maaori	87.8%	90%
	Total	88.4%	
Number of people with diabetes who have seen a podiatrist	Maaori	_ ²⁹	_ ³⁰
	Total	6,147	

Actions

- Q1: Implementation of a new targeted model of care, to focus on patients with poor glycaemic control, and introducing virtual reviews between primary and secondary care
- Q1: Clinical Governance – Maaori representative to be appointed to the Diabetes Service Level Alliance Team (SLAT)
- Q1: Five Diabetes Indicators will be reported by ethnicity so performance can be monitored and analysed with the aim of reducing variation between practices and variation between ethnicities.
- Q1: Implementation of a diabetes collaborative model with a selected group of practices (practices with high numbers of Maaori patients with poorly controlled diabetes will be targeted), to test new targeted models of care
- Q1: Ensure Maaori are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings
- Q1: Ensure Maaori who have high risk feet are identified proactively within primary care and referred to a podiatrist for ongoing care
- Q1: Maaori with poor glycaemic control will be offered enrolment into the At Risk programme which includes a care plan, self-management assessment and named care co-ordinator
- Q2: Practices will work to identify Maaori who have not had a retinal screen, or who are overdue for a retinal screen and ensure they are referred to the service or followed up
- Q1: Improved access to self-management support services, including self-management education, to enhance health literacy, healthy lifestyles, adherence to medication and overall health and wellbeing for Maaori patients and whaanau with diabetes
- Q2: Practice Nurses who work in practices with high numbers of Maaori patients with diabetes will be encouraged to attend the Manukau

Who will we work with?

- Northern Region Diabetes Network
- Primary care and secondary care clinicians and Clinical Champions
- Integrated Care Clinical Governance Group
- Diabetes Service Level Alliance Team
- Diabetes Projects Trust

Monitoring Processes

- Quarterly reporting to MHAC, ELT & ALT
- Quarterly reporting to the Diabetes SLAT
- Quarterly reporting to the MOH

²⁹ Maaori baseline to be established in 2016/17

³⁰ An improvement on baseline target to be set once baselines have been established

Institute of Technology Diabetes Care and Management course

- Q1-Q2: Establish baseline data for Maaori for number of people with diabetes who have seen a podiatrist
- Q3: Set target for podiatry measure once baseline has been established

6.1.5 Childhood Obesity

CM Health has been identified as one of the DHBs with a high rate of overweight and obese children who require additional care and advice. Thirteen percent of 4 years olds were identified as being obese (>98th percentile) at the time of their B4S check in the 6 months to January 2016. Unhealthy diets and lack of physical activity are key determinants of obesity which in turn impacts on health both in childhood and in later life. The long term consequences of obesity include chronic diseases such as diabetes, CVD and osteoarthritis.

CM Health will undertake activity in order to contribute to the reduction in childhood obesity, including through contribution to the health sector actions in the national Childhood Obesity Plan. We will develop a new culturally acceptable Family-based Nutrition, Activity and Lifestyle Intervention Service for children, and their whaanau, who are identified as obese during their B4S check.

This work will link to wider outcomes to improve health for all population groups across different provider and funder groups. We will ensure that initiatives support a reduction in obesity for Maaori and Pacific families and whaanau, and children living in high deprivation areas.

Actions

Sector review

- Undertake a stocktake in Q1 and Q2 of current physical activity and nutrition programmes available in the region, and review evidence of effectiveness of such programmes
- Identify other initiatives across sectors such as Healthy Auckland Together, Healthy Families NZ, family based diabetes prevention programmes such as H.O.P.E (healthy options positive eating), and H.E.A.L.S (healthy eating active lifestyles) to ensure alignment and leverage against existing programmes
- Work with key stakeholders across health and other sectors to support implementation of the obesity package of initiatives

New service

- Develop multidisciplinary alliance with WCTO providers, primary care and community partners
- Implement appropriate referrals pathways to ensure families experience seamless transition and support post referral from the B4 School Check to Primary Care for clinical assessment. Expedited pathway for Maaori and Pacific children
- Implement culturally appropriate Family-based Nutrition, Activity and Lifestyle Intervention Services for children identified as obese at their B4S Check; services to include post-intervention framework, specifically targeted to Maaori, Pacific, and families from high deprivation communities Q2
- Implement the Northern Regional (Childhood) Obesity Prevention pathway to ensure primary care have access to appropriate resources to support conversations with families, identify metabolic complications of obesity, and are clear when referral to secondary and/or family nutrition,

Percentage of obese Tamariki identified at B4SC referral to a health professional for clinical assessment		2015/16 Baseline	2016/17 Target
	Maaori	³¹	95%
	Total	³²	

Measures

- Stocktake completed by Q2
 - Appropriate alignment to avoid duplication of service
 - B4 School practice nurses have been trained in referral processes and guidelines and electronic growth chart solution for primary care by Q1
 - PHOs have been trained in process, regional guidelines, electronic growth chart solution and resources for GP practices by Q1
 - 100 percent of GP practices have received training, regional guidelines and resources by Q2
 - Implement regional guidelines, electronic growth chart solution and resources for clinical staff in secondary and tertiary care over Q1-Q2
 - Implementation of the family based Lifestyle Nutrition and Physical Activity intervention provider contracts by Q1
- Implement Quality plan and reporting for referrals, use of the regional guidelines and electronic growth chart by Q2
- 100 percent WCTO trained by Q4
 - Training module developed by Q2
 - ECE resources and training developed aligned to NZ Heart Foundation programme
 - 50 percent of ECE trained and resourced targeting high Maaori and Pacific rolls, high deprivation by Q2
 - Remaining ECE trained and resourced by Q4
 - Water and milk promotion Q3-Q4

³¹ Baseline to be established in 2016/17

³² Baseline to be established in 2016/17

activity and lifestyle intervention services is appropriate

- Implement regionally consistent guidelines and electronic growth chart solution for primary care and B4SC providers, consistent with MOH advice by Q1
- Implement and monitor guidelines for clinical staff working in secondary or tertiary care response when children are assessed as obese
- Monitor adherence to weight assessment guidelines by clinical staff working in secondary or tertiary care
- Referrals to At Risk programmes for children/families who meet the eligibility criteria
- Liaise with school based programme “Mana Kidz” and Health Promoting Schools (HPS) to ensure they are working with schools to develop healthy food policies and health promotion around nutrition as a core part of their daily work

Workforce development

- Upskill WCTO workforce on infant and family nutrition using health literacy model, and develop family-based healthy nutrition initiatives
- Develop a training module for primary care to upskill workforce on infant and nutrition family discussions using health literacy framework
- Upskill Community Oral Health services to ensure consistent nutritional advice is received by parents and caregivers of preschool children
- Training module and resources for ECE, preschools, language nests, Kohanga Reo to upskill staff and volunteers using the health literacy module and aligned to the curriculum Te Whaariki for healthy nutrition and exercise. The initial module will target ECE centres in high deprivation localities with high roll of Maaori and Pacific children
- Continue to work with midwives and self-employed LMCs around the implementation of the Healthy Weight in Pregnancy guidelines

Sector alignment

- Oral Health education is provided to parents and caregivers by WCTO Providers at all core contacts, and includes Lift the Lip exam, advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments
- Nutrition messages should be consistent across settings
- Liaising with ECE, preschools, Language Nests, Kohanga Reo in the region for implementation of nutrition and preschool activity guidelines consistent with MOH advice and aligned to Te Whaariki (ECE curriculum)
- Co-design a culturally relevant local promotion to WCTO, COHS, ECE of swap sugar sweetened drinks to water or milk as part of oral health literacy promotion Q3-Q4

Appendices

Appendix 1: Hauora Plan – 2012 to 2017



Hauora Plan – 2012 to 2017

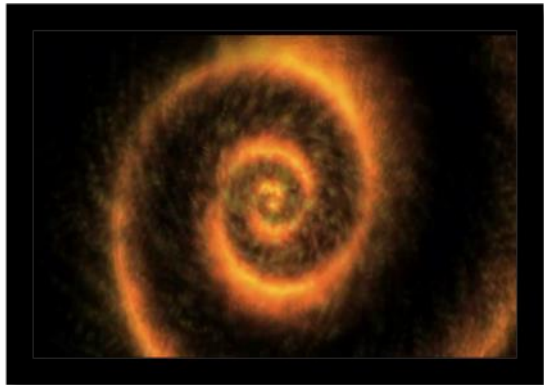


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Kupu whakataki - Preface

He haerenga uaua - a difficult journey



The decision by Mana Whenua to claim a space in the health sector and improve Maori wellbeing was made 12 years ago, during the drafting of the Health and Disability Act 2000. Through the efforts of Tariana Turia, Associate Minister of Health at the time, attempts were being made to recognise the status of Te Tiriti o Waitangi and the role of Mana Whenua in the Act. Concerns about the position of Maori health and a commitment to work together provided an opportunity for local hapu to collectively form a shared governance arrangement with Counties Manukau District Health Board. Thus a Memorandum of Understanding was shaped between the parties.

The different interpretations of shared governance however became a bone of contention during the development of the MoU between Mana Whenua and CMDHB. In addition to challenges concerning the authority of both parties to enter into a relationship based on Te Tiriti o Waitangi, the journey over the last 12 years has been an arduous one. Although the Memorandum was signed in 2000, an 'understanding' had never really been reached, and as such the relationship between the two entities has been wrought with difficulties and unresolved issues.

He timatanga hou – a new beginning

The unique appearance of Matariki in 2012 signalled a significant distinction more so than in any other year according to well known astrologist Dr Rangi Mataamua. Observers have noted that for the first time, Matariki has risen right alongside Parearau (Jupiter) and Tawera (Venus) signalling an unusual alignment in Te Ao Maori. Mataamua considers that this extraordinary event signifies the presence of two major issues facing Maori at this time. Some practitioners identify those issues as Matauranga Maori and Hauora Maori while others consider Maori leadership and tikaanga as prominent matters.



However interpreted, this occurrence has emerged at a time most appropriate for Mana Whenua to review the past, assess the present and plan a future of improved Maori wellbeing.

Therefore the completion of the Hauora Plan heralds a new beginning in relationships, energies and efforts to make a significant difference in the lives of whanau.

This document is an invitation to Health authorities to re-establish a purposeful, Treaty based relationship with Mana Whenua i Tamaki Makaurau. There is an incredible amount of work to do, given that Maori in Counties Manukau are more likely to be unwell than Maori living in any other region of Aotearoa. Such a situation is simply unacceptable, and in order to transform Maori wellbeing, the collective efforts of all stakeholders have to be consolidated in a way that has never been attempted before.

Nga Mihi - Acknowledgements

There have been numerous people who have contributed to this work both purposefully and unintentionally. To all who have participated through commitment, dedication and a commonality of purpose, our members acknowledge you.

Te Roopu Waiora Trust working to ensure whanau haua are brought back into the fold of their communities, we thank for their generous gift of the adaptation to Hua Oranga, a whanau outcome measurement tool. This tool developed by the Maori studies Dept of Massey University, after numerous changes by Te Roopu Waiora to improve usability and access, has a significant place in this Hauora Plan.

We also acknowledge the Health Sponsorship Council and Ian Potter, brave enough to support the development of Mauriora, and the exceptional team led by Katerina Te Heikoko Maitaira whose life was dedicated to the wellbeing of our people. To Moana Jackson, New Amsterdam Reedy, Cathy Dewes, Tane Cassidy, Tahuna Minhinnick, Shane Bradbrook, Riripeti Haretuku, Tania Kingi and Eru Potaka Dewes our appreciation for contributing to the debate and pursuing another philosophy on wellbeing in the form of Mauriora that has guided this Hauora Plan. We also thank Tania for the immense work in putting this document together, leading the consultation hui and working with our members to bring these strategies to our communities.

We acknowledge too the development of a Treaty framework by Kere Cookson-Ua and Ngati Whatua which has been generously shared and adapted in this Hauora Plan. Also the many providers of health and wellbeing services whose work is often scrutinised but rarely honoured. In particular Te Ora o Manukau, for their continued acknowledgement of our role in this rohe and support of the Treaty framework contained within - such a crucial part of moving forward. Counties Manukau District Health Board, thank you for your contributions toward this plan both financially and in the information you have shared. We look forward to a much improved relationship in the future.

Finally our members, both past and present. It has been a daunting but rewarding journey to get us to this point and many of our founding members have since passed on. We acknowledge the incredible struggle to establish a meaningful, working relationship, the many lessons along the way, and the good will that still exists to continue this lifelong pursuit.

Nga mihi kia koutou katoa

Nganeko Minhinnick
Chair Mana Whenua i Tamaki Makaurau

Introduction

This Hauora Plan is a collective effort by the members of Mana Whenua i Tamaki Makaurau and the many contributors committed to Maori wellbeing. Its creation will assist position Mana Whenua to expand Hauora Maori and progress the various relationships needed to make the necessary improvements. The strategies contained within will further clarify the role of Mana Whenua and that of the Crown and its agencies, along with those communities and service providers that share a common purpose.

The overall goal of this plan is to ensure that the policies, resources and services delivered within this rohe are responsive, equitable and improve the wellbeing of whanau.

Overview

According to various academics, long-term goals being applied by Crown agencies are lacking a clear sense of Maori responsiveness, ownership and self determination. Analysts advance that the government's many changes of direction in recent years shows that generally 'Crown policies regarding the Treaty of Waitangi'¹ and Maori responsiveness have been formulated in response to political events of the day'².

Most Crown agencies have conveniently sidestepped obligations to the Treaty by diminishing or deleting references in their key documents or initiating debates regarding Treaty relationships or partnerships, principles and articles, iwi or hapu, mataawaka or Mana Whenua. The impact this has on Maori was articulated in the Public Health Association's submission to the parliamentary select committee, advancing that without Treaty references 'we run the risk of returning to an era where Maori were expected to passively accept decisions made outside their communities.'³

Further alienation of the Treaty occurs through diluting the status of Mana Whenua to that of advisory committee or using the 'multicultural' rhetoric to 'treat all communities the same'. Maori health plans and strategies developed by health authorities are no exception. Ignoring Treaty issues prevents Mana Whenua from deciding Maori advancement at a time when 'Maori are afflicted by higher rates of disease than the non-Māori population, receive treatment later and of lower quality, and have poorer outcomes'⁴. According to the Global Report⁵, New Zealand is characterized by some of

¹ The use of the term 'Treaty' in this document refers to the version written in Te Reo Maori

² Williams, D (2002) Honouring the Treaty of Waitangi: Are the parties measuring up?

³ Referenced by Hon.Tariana Turia re: submissions currently being presented on the Public Health Bill – April 2008 from <http://www.maoriparty.com/>

⁴ Downloaded from: www.thelancet.com volume 378, 12 November 2011

⁵ ibid

the largest health disparities between Indigenous and non-native populations in the world.

It must be understood that because vote health funds are received by health authorities and not Mana Whenua, this plan in no way assumes the responsibility of CMDHB. Every health authority must be held accountable for the current position of Maori health. Decisions regarding resource allocations, service menus and health priorities that impact on Maori must be carefully and consistently scrutinized internally and externally; in an effort to redress the underperformance of the health sector regarding Maori health gain. There has always existed a critical role for Mana Whenua; not operationally as a service provider, but as a legitimate Treaty partner functioning at a governance level. Health authorities should recognize that properly resourced agreements with Mana Whenua to exercise a treaty partnership are fundamental to improving the health sector's performance.

Position Statements

While most Crown Agency decision makers may be unable or unwilling to understand the relationship between breaches of the Treaty of Waitangi and Maori illness and deprivation, developments by Maori authorities are almost always underpinned by the Treaty in an effort to claim the space for self determination. Mindful of this, Mana Whenua i Tamaki Makaurau have developed a Treaty-based Hauora Plan. It is a document that articulates our pathway forward, signposted by several clear position statements:

- Counties Manukau sits within the rohe of Mana Whenua i Tamaki Makaurau; the legitimate entity with which to secure a Treaty relationship with the Crown and its agencies
- True partnering with health authorities and relative Crown Agencies will support the planning and operation of competent, high quality services to Maori within this rohe
- Mana Whenua i Tamaki Makaurau as an independent authority has an important role in evaluating providers and funders resourced to improve Maori wellbeing
- In this rohe MWiTM is a key contributor to defining tikaanga Maori practice in the provision of health services to Maori.

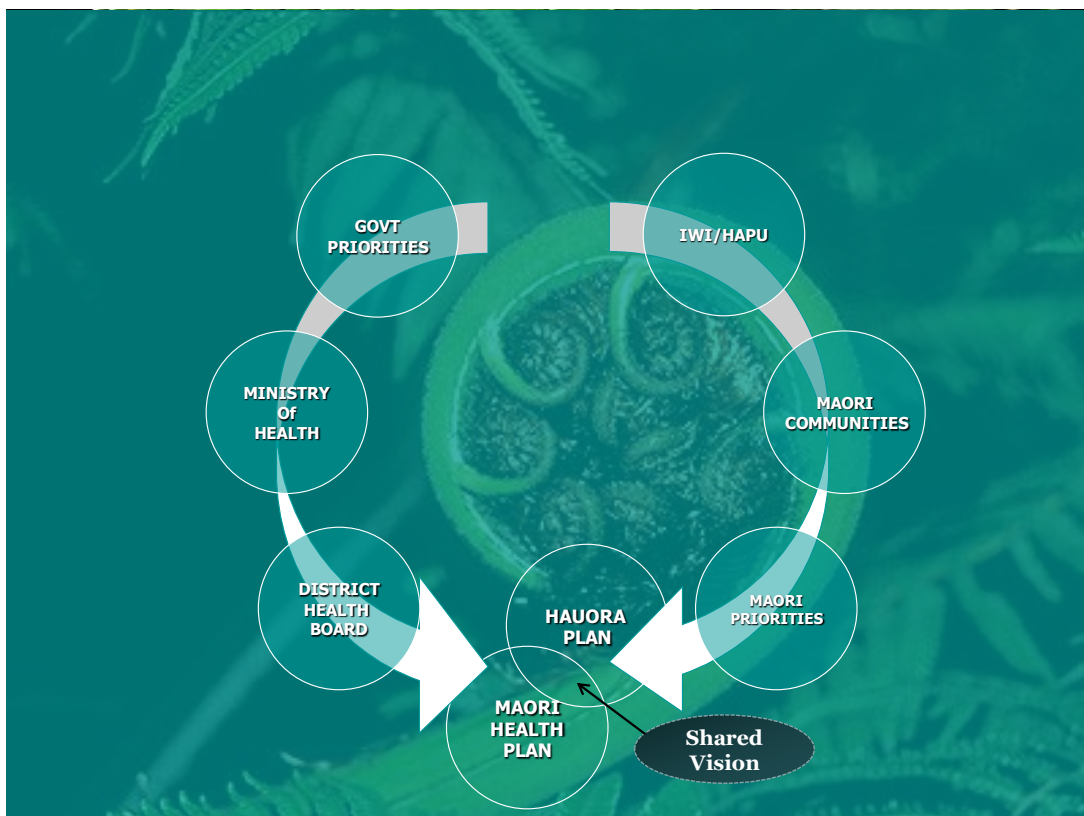
Our Process

Over the last 12 months Mana Whenua have explored and debated these position statements within the context of hauora. A broad analysis detailed in an earlier position paper provided to Mana Whenua has informed this plan. Four key principles have been determined, each with a number of strategies. The Hauora Plan's key principles are:



Review and Sample

In August 2011, a review was undertaken by Mana Whenua of the draft Maori Health Plan from CMDHB. Presented as an Action Plan and obviously written to direct the CMDHB, the review was helpful to analyse process, priority areas and gaps related to Maori health. This confirmed for Mana Whenua the direction the Hauora Plan would take. The different pathways are best illustrated in the following diagram:



By building on a common purpose while acknowledging the different pathways the government and Mana Whenua have taken, the Hauora plan has captured a foundation for strengthening roles and future relationships.

A tested whanau outcome measuring tool adapted by one of our local organisations was also trialled by Mana Whenua in October 2011 to inform the Hauora Plan. This exercise illustrated the value of a whanau centred evaluation process measuring wellbeing principles to determine service quality. The findings indicate a much needed system that will yield valuable consumer driven information. As a result, this is included as a key strategy.

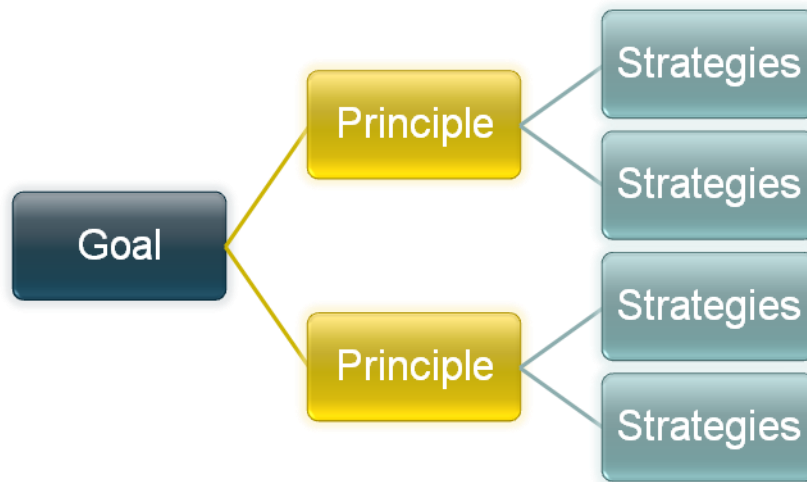
To further support the development of this plan, a survey by Mana Whenua representatives was carried out targeting whanau among various hapu in December 2011. Reviewed alongside a study of whanau aspirations undertaken by a local whanau ora initiative, the findings identified priority areas among Maori communities – and more importantly, the need to ensure whanau aspirations are a major component in determining the menu and approach from health services to Maori.

Four consultation hui have been held seeking feedback from marae, hapu, whanau, government representatives, service providers and communities from March 2012 to date. We will continue to invite feedback from Maori as we implement the strategies contained within.

It is understood that this plan constitutes a first step to realise the overall goal of Mana Whenua i Tamaki Makaurau. Although there is a strong health focus, the concept adopted is far broader and more appropriate for Maori wellbeing, which for the purpose of this document; we have referred to as hauora Maori.



Structure of the Hauora Plan



Goal

To ensure policies, resources and services within the rohe of Mana Whenua i Tamaki Makaurau are responsive, equitable and improve the wellbeing of whanau

Treaty Partnership - principle 1

Implement the Treaty framework to progress relationships with stakeholders responsible for improving and monitoring Maori wellbeing

Develop agreements with Crown agencies that commits resources, goals and measures to progress this framework

Establish engagement protocols as the basis of all future relationships with Mana Whenua i Tamaki Makaurau

Matauranga Maori - principle 2

Assist stakeholders recognise and support the validity of tikaanga and matauranga in progressing hauora Maori

Collaborate with stakeholders to determine key Maori competencies for the local health workforce

Develop a broader platform of Maori health that aligns with Hauora within a whanau ora environment

Services Planning - principle 3

Establish an operational division that will work with the Crown to implement the strategies of this Hauora Plan

Source and incorporate whanau goals and aspirations in the planning of policy and service provisions

Establish a governance partnership with CMDHB to review and plan the progress, resources and services within the Counties Manukau area

Whanau based quality - principle 4

Secure resources to trial and implement whanau evaluation processes and Maori outcome measures

Establish a service benchmark that supports service engagement and responsiveness to Maori

Implement appropriate methods to involve Maori communities in decisions to improve Hauora Maori

The Treaty Partnership

‘Because social and economic policies are so closely linked, and because avenues of active participation in decision making and policy formation are critically important, the significance of the Treaty as a force for social well-being should not be underestimated. Its cursory treatment in the past cannot be accepted as a reason for its exclusion from arenas where future planning occurs’.⁶

Mana Whenua i Tamaki Makaurau have focused on a Treaty framework that establishes meaningful working relationships from which to progress Maori wellbeing. Although a number of treaty frameworks exist; the most appropriate, not only in resolving some of our past challenges but guiding our future, was developed by Ngati Whatua⁷. It is evident when reviewing the most recent Auckland District Health Board annual plan that the Ngati Whatua/ADHB relationship has influenced the planning of Maori health. The intent of this Hauora Plan is to capitalise on existing energy to lift the planning and the performance of the health sector, stakeholders and Maori communities, through a clear understanding of roles and obligations.

It is fitting that the Treaty underpins this Hauora Plan. The Treaty has been portrayed as ‘the first Maori health strategy,’ describing a Maori population in sharp decline following the impact of ‘unmanaged colonisation.’⁸ Busby raised concerns in 1837 of the ‘miserable condition of the natives’ which he reported if left unchecked would result in the extinction of the Maori race. Whether this was the real motivation behind Busby’s actions still remains contentious today. However his unease over the health and welfare of Maori, to which he placed some of the blame on the total European impact,⁹ was a factor in persuading the British Colonial office to propose a Treaty to Maori.

Such was the contrast to earlier references by the first immigrants that described Maori as bountiful, healthy and vibrant. The Crown offered protection of land, culture and wellbeing, resources and the continued ability of the tribes to control their interests in the form of a Treaty. Despite controversy and debate by the chiefs of the hapu regarding the intent of the Crown, ‘concerns over Maori health were not insignificant in terms of both shaping and selling the Treaty to Maori.’¹⁰

Much has been debated concerning the history and validity of the principles as applied to the Treaty of Waitangi. This Hauora Plan advances the importance of the articles although it is acknowledged that the principles are the Crown’s interpretations of a document yet to be properly honoured by successive governments. Over time specific strategies based on the articles will be developed for more detailed planning exercises.

⁶ Kawharu I (ed): 1994, p 287

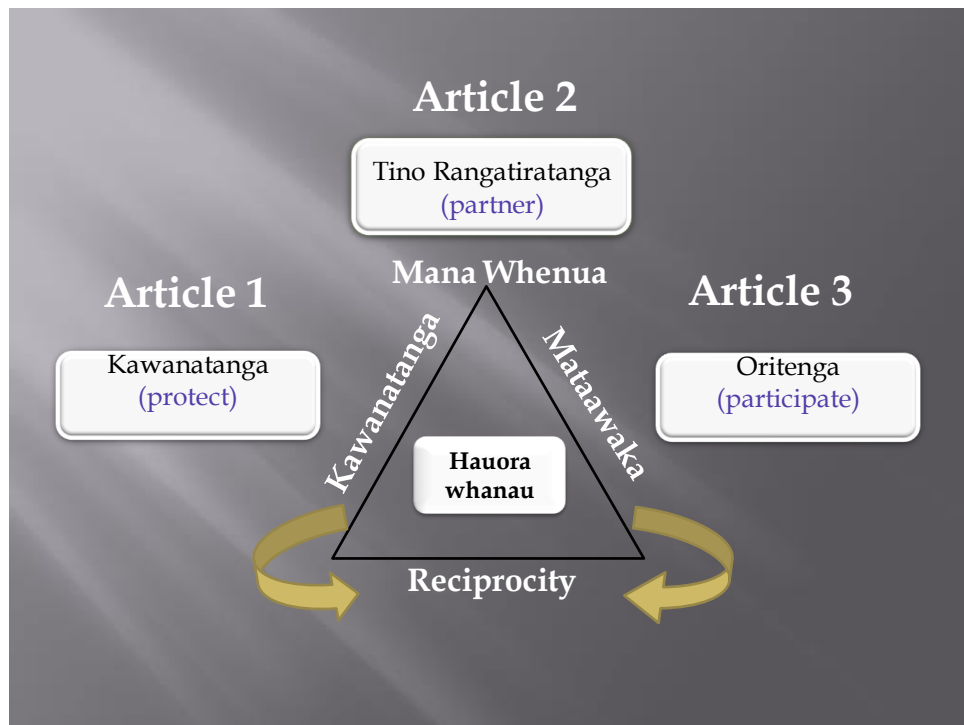
⁷ 2011 presentation by Kere Cookson Ua, CEO of Te Kahu Pokere, Te Runanga o Ngati Whatua

⁸ Kingi, TKR (2006) *The Treaty of Waitangi and Maori Health*. Te Pumanawa Hauora, School of Maori Studies, Massey University, Wellington

⁹ Orange, C (1987) *The Treaty of Waitangi*, p25. Allen & Unwin NZ Ltd, Wellington

¹⁰ Kingi TR (2006). *Culture, Health and Maori Development: A paper presented at the Te Mata o te Tau Lecture Series*, Palmerston North

Treaty Framework in Action



In brief the Treaty has three main articles that in contemporary times and through NZ case law have been aligned to the three principles of protection, partnership and participation. The Hauora Plan recognises the articles and the intent of the principles within the original framework from Ngati Whatua.

Article one – Kawanatanga and the obligation to exercise protection by the Crown. The government and its agencies have a responsibility to protect the rights conferred in articles two and three.

Article two – Tino Rangatiratanga and the right of Mana Whenua to enter into partnership with the Crown. Mana Whenua maintains this responsibility, while ensuring those who reside within their geographical areas are supported to exercise their right of participation.

Article three – Oritenga in terms of equitable participation by Mataawaka - Maori and non Maori in the provision of services to improve Maori wellbeing. While Mana Whenua supports quality service provision within its rohe, in terms of reciprocity, Mataawaka participation supports Mana Whenua to exercise their right to rangatiratanga through the process of a Treaty partnership.

There should be no further misunderstanding of the position Mana Whenua holds within their rohe. Not to be confused with iwi from other areas, urban Maori communities or

service providers, the framework guides the way forward in terms of Treaty obligations and relationships with the Crown, its agencies and Mana Whenua i Tamaki Makaurau.

“Indigenous peoples have regrouped, learned from past experiences, and mobilized strategically around new alliances. Many indigenous communities are spaces of hope and possibilities, despite the enormous odds aligned against them...tribes and nations are in dialogue with the states which once attempted by all means possible to get rid of them.”¹¹

Matauranga Maori

The New Zealand Health and Disability Sector Standards require services to identify and respond to: “cultural values and beliefs of Maori service users and their whanau, and seek to provide services that promote:

- Tikanga a iwi and hapu (the use of appropriate protocols for dealing with tribes and sub-tribes)
- Tino Rangatiratanga (sovereignty)
- Whanaungatanga (extended family wellbeing);
- Te taha tinana (physical well-being);
- Te taha wairua (spiritual well-being);
- Te taha whanau (family well-being);
- Te taha hinengaro (mental well-being);
- Te taha matauranga (learning)¹².

The values and principles listed above are by all accounts fundamental to the improvement of Maori wellbeing and are necessary elements to ensure whanau decision making and participation occurs. However much of the available resource has largely concentrated on service provision dominated by clinical practice. If such an approach yielded the same health status for Maori as it does for Pakeha, there would be no issue. But it does not; and there is little resource invested in the capacity building of whanau to determine their own health journey using Maori knowledge and practices. Furthermore, it is not a matter of one type of development in favour of another.

This Hauora Plan promotes an environment where cultural pathways warrant equal attention. Communities and organisations providing services nurtured by Maori principles must be appropriately resourced in terms of capacity; but so too must whanau be capable of selecting and utilising services, making their own choices and collectively managing their wellbeing.

Maori principles are not considered or determined in any appropriate, structured way when deciding health services to Maori. Yet they should be if we are to collectively make necessary improvements to Maori wellbeing. Through this Hauora Plan, Mana

¹¹ Smith, LT (1999): Decolonizing Methodologies – Research and Indigenous Peoples

¹² Standards New Zealand (2003) p21

Whenua i Tamaki Makaurau is positioned to *set and monitor* the benchmark of cultural practice as applied by stakeholders operating within this rohe. Work is already underway to not only validate Maori wellbeing through concepts of hauora, mauri ora and whanau ora, but to recognise poor attempts to culturally flavour service provisions in an effort to maintain funding levels. Hauora should for its people, encapsulate the life essence or Mauri ora from principles and practices such as:

Oranga wairua: Spiritual Wellbeing

Nga Rangituhaha (the abode of the supernatural); nga tikaanga hei whakatau i te wairua (the rituals and practices to acknowledge wairua); te wairua – Te Ira Tangata (the spirit – the life principles of mortals); nga tohu o te wairua ora (the indicators of spiritual wellbeing).

Oranga tinana: physical wellbeing

Nga tikaanga whakapiki i te ora o te tinana (the rituals and practices to raise physical wellbeing); nga tohu o te tinana ora (the indicators of physical wellbeing)

Oranga Taiao: environmental wellbeing

Te ahua o te taiao (the presence of the environment); nga tikaanga tiaki i te taiao (the rituals and practices for looking after the environment); nga tohu o te tangata manaaki i te taiao (the skills and knowledge of a person to look after the environment); ngahere ora (thriving forest); wai ora (safe, clean water)

Oranga whanau: family wellbeing

Nga whanau o mua (families of times past); nga matapono o te whanau ora (the principles of whanau wellbeing); he whanau ake (specific whanau groups); nga tohu o te whanau ora (indicators of a well and healthy whanau); oranga tangata (individual wellbeing).¹³

Whareoranga developments are seen as important initiatives where clinical health (particularly GP based) and Matauranga Maori can be effectively combined using a Hauora framework. For this reason their maintenance and growth is a key priority for Mana Whenua.

¹³ Developed by the Mauriora working group led by Katerina Te Heikoko Mataira and published in 2012

Services Planning

It is obvious with the growing demands on health services and the limited resource available that more must be done with less. Besides concerns regarding bureaucratic wastage, ballooning health costs and excessive administration; attention also must be paid to both the menu and effectiveness of service provisions – and in particular, how Maori priorities have been considered in the process of decision making. An exercise undertaken recently by a group of whanau developing their goals and aspirations for wellbeing produced a range of service needs not currently provided in Counties Manukau. A second exercise undertaken by Mana Whenua to identify priorities among whanau from a number of hapu and iwi again revealed a range of services that were similar but also different to those that exist.

What would happen if the planning of services to Maori was undertaken to deliberately and directly include whanau priorities and aspirations? We are confident that such an approach would not only improve Maori utilisation and engagement but lift the status of whanau health and wellbeing. There is ample research to evidence that this is the case, and the attempts by whanau ora initiatives to adopt this approach have been designed on this premise.

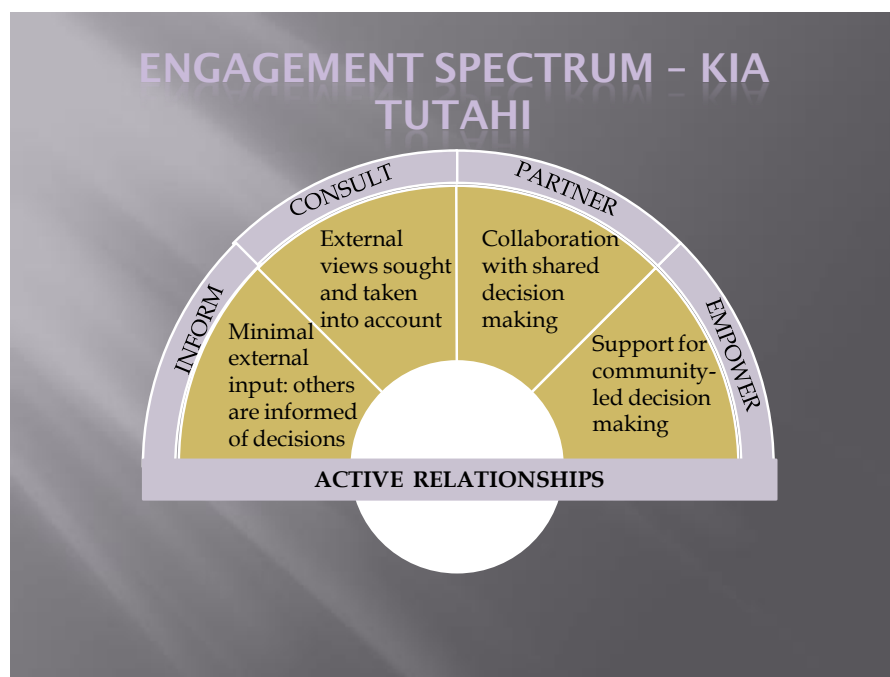
In a recent publication of the Lancet¹⁴ the deputy director-general of Maori Health from the Ministry of Health stated that the health system has been complicit in propagating inequalities. According to Theresa Wall, the disparities especially over the last 20 years largely indicate improvements in the health of non-Maori that have not been matched by equal progress in the Maori population.

Furthermore Wall states that public health interventions designed for the general population and delivered through mainstream service providers often failed to take into account the barriers that might prevent Maori from accessing them. Such an admission offers a way forward for Mana Whenua and health authorities to work together in addressing the disparities, eliminating the barriers and ensuring those same improvements to Pakeha health are mirrored among Maori populations.

A way to ensure communities play more than a cursory role in services planning is to strengthen their presence in creating relationships of value. In August 2011, the Kia Tutahi Relationship Accord was signed by representatives on behalf of the communities of Aotearoa and the Prime Minister on behalf of government. The accord illustrates a stronger commitment by the parties to ensure improved relationships – not only between the government and the communities of Aotearoa, but also individuals and

¹⁴ Downloaded from: www.thelancet.com volume 378, 12 November 2011

service users. The illustration below¹⁵ provides a progressive spectrum Mana Whenua have included as a guide to strengthen the relationships to progress this Hauora Plan.



The Health Landscape

In this region identifying resource allocations for the provision of health services to Maori is a difficult exercise. Whereas the data from CMDHB to quantify services to Maori as well as funding levels to Maori organisations is available; identifying the same in relation to Pakeha organisations is an entirely different matter. There are a number of reasons why this is the case. Poor ethnicity data collection by Pakeha services is a primary concern and more must be done to ensure accurate and timely reporting. The competency levels of the health workforce responsible for ethnicity identification, data collection and reporting is also an issue as not enough importance is placed on the way in which information should be collected and recorded from Maori.

From a funding perspective; varying units and their distinct costs across providers make comparisons impossible. Bed nights, hourly rates, programme costs and bulk funding data is available but of no real use when attempting to ascertain overall resource allocations in relation to the services purchased and usage across various populations. There are over 300 CMDHB contracts currently in place for health services in this rohe and it appears to be an ongoing struggle to glean the necessary information regarding

¹⁵ Kia Tūhahi Relationship Accord – Guide produced by the Office of the Community & Voluntary Sector (2011)

costs and services to Maori. Strategies of this Hauora plan focus on working with Health authorities to identify the level of services and resources to support Maori health and determine how and what improvements can be made.

Whanau based Quality

As the service landscape shows signs of transformation towards consumer and patient centred healthcare, attention to measures of wellbeing are gaining momentum; particularly as Whanau Ora initiatives extend across the regions. Outcomes rather than outputs and inputs, as a measure of service quality have also gained wider traction, amid challenges regarding validity, credibility, suitability and accuracy.

In the health sector, universal measures relevant to all people are applied as instruments to measure Maori wellbeing, such as life expectancy, mortality data and immunisation rates. This application is based on the notion that all people have common views about being well therefore wellness can be measured in similar ways. There are however unique Maori characteristics to wellness that requires specific measurement. All too often these are misunderstood and ignored in the health sector.

Coordinating outcome measures for Maori and identifying what level indicators are most appropriate, deserves dedicated study. Winnard has identified concern that 'whanau progress was being measured against indicators that reflect economic concerns (ie. reducing hospitalisations).'¹⁶ Similarly McPherson and others point out that 'most measures of process and outcome are based largely on Eurocentric or American perspectives.'¹⁷ Though such approaches have a place, they fail to address issues that matter most to Maori.

A number of health authorities have adopted outcome measuring systems from off-shore due to a lack of suitable and appropriate measures being developed in New Zealand. A popular tool is the SF36 quality of life measure introduced in over 47 countries with reviews from both France¹⁸ and Bangladesh claiming its usefulness as a measuring tool if modified for cross-cultural adaptation.¹⁹ The appeal of the SF36 is that it is a self assessment, quality of life measure that:

- Describes functioning and wellbeing of individuals with and without medical conditions
- Provides outcome criterion for interventions

¹⁶ Winnard, D (2007) Indicator frameworks and tools for contract monitoring and evaluating programmes for Maori health gain: A review

¹⁷ McPherson K, Harwood M, McNaughton HK (2003): Ethnicity, equity and quality: Lessons from New Zealand. BMJ Publishing Group

¹⁸ Legplege A (2003) The French SF-36 Health Survey Translation, Cultural Adaptation and Preliminary Psychometric Evaluation. Journal of Clinical Epidemiology , Volume 51 , Issue 11 , Pages 1013 - 1023

¹⁹ Ahmed SM, Rana AK, Chowdhury M, Bhuyia A (2002) Measuring perceived health outcomes in non-western culture: does SF-36 have a place? Journal of health, population and nutrition Dec;20(4):334-42

- An aid for decision-making in the healthcare field²⁰

The dimensional structure of the SF36²¹ parallels western theories of health which place it at a distance in terms of an appropriate measure of Maori health and wellbeing. Primarily the SF36 fails to incorporate spiritualism and whanau connectedness as quality of life factors. To overlook these dimensions illustrates the notion that western principles apply to all cultures and peoples. Such a misconception should be challenged when transposed to interpret Maori health experiences. If results from measures influence the design and type of services targeting Maori and purchased by funders, then these tools must be deconstructed and assessed for cultural integrity. The lack of comparative health gain to Maori demands it.

Cunningham proposes that mainstream measures health rather than hauora. While tools applied by health authorities measure physical health, mental health and independence; Maori concerns include spiritual, whanau and environmental wellbeing. 'Hauora is not the Maori word for health. It is related but different in concept. There are collective and social elements to it.'²²

A theory behind most outcome measuring tools is that the user is a prepared participant willing to divulge intimate information useful to the process. Much depends on objectivity within a safe and trusted environment free from service influence. Furthermore the *preparedness* of Maori users to engage in these processes is often overlooked; particularly if poor experiences have occurred in the past. Some might argue that this is the point of evaluation systems, however if the evaluation in itself is a contributing factor to anxiety, results are likely to be inconclusive. The 'pre-evaluation environment' requires some effort and attention quite apart from those services being evaluated.

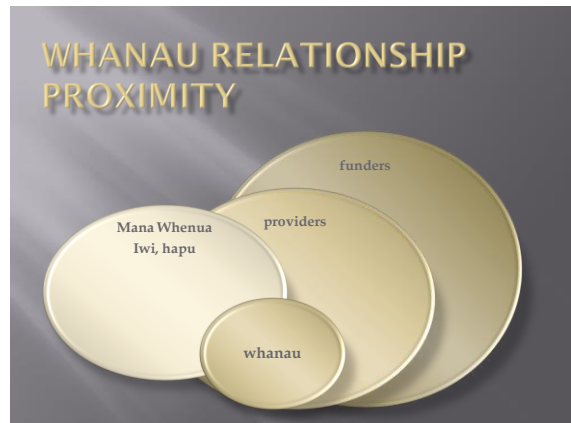
Recognising service quality is just as important as the process of evaluation. The idea of acknowledging Hauora Maori service excellence deserves support and consideration. Reaching the cultural practice benchmark by providers as determined by results from whanau evaluation processes should be acknowledged in a simple yet effective way – much the same as the National Heart Foundation's tick of approval.

The extent of this work is significant. The first step for Mana Whenua is to develop an operational structure that will provide a vehicle to evaluate services experienced by whanau. The trials undertaken during the formation of this plan have revealed the relationship required with whanau as well as the means to access and engage the local Maori population, develop an environment of trust and support whanau assume their natural roles of shared obligations.

²⁰ Bullinger M, Schmidt S: The Challenge of Cross-Cultural Quality of Life Assessment, Institute of Medical Psychology, University of Hamburg. Downloaded March 2008 from www.bath.ac.uk

²¹ Short Form 36 (SF36) designed for use in clinical practice and research, considers eight aspects of health.

²² Cunningham, C (2002) Massey University Magazine, Issue 14



Over a period of time the infrastructure planned by Mana Whenua will provide the working arm to progress the strategies contained within. Each strategy is interconnected but can be progressively built from the Treaty framework.

Mana whenua recognize not only its obligations to those within its tribal boundaries but the position to remain independent from service provision. The intent is to objectively ensure that high quality, effective services are invited and supported to operate within the rohe of Mana Whenua i Tamaki Makaurau. To do so means a different relationship with health authorities that shares decision making concerning Maori health and wellbeing. This is the space where a shared vision exists between Maori health and Hauora Maori. The Hauora Plan is a governance tool to navigate the way forward for Mana Whenua much the same as the District and Annual Plans do for the CMDHB. An opportunity now exists to ensure planning is progressed from a secure Treaty partnership in spite of a history of mistrust and misdemeanors.

Conclusion

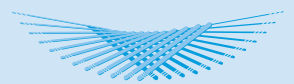
No problem can be solved from the same level of consciousness that created it.
Albert Einstein

As well as the opportunities such initiatives bring, there are also many challenges to overcome to implement this Hauora Plan. Transforming and building roles and responsibilities internally is a significant undertaking but necessary to transform the external environment as described within.

Across the health sector the present systems and decision making structures have not worked for Maori, and it is unwise to continue much of the same in the hope that improvements will result while ignoring decades of systemic failure. Subsequently the future will require a kind of leadership that serves its people thereby creating a domain where whanau map their own way forward in the pursuit of Hauora Maori.



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